

University of Nevada, Reno

**Angels on the Head of a Needle: Constructing Socially  
Meaningful Space in a Syringe Services Program**

A thesis submitted in partial fulfillment of the requirements for the Degree of Master of  
Arts in Anthropology

by

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*Abstract*

People who inject drugs, people experiencing homelessness, people living with HIV and others converge daily within Change Point, Nevada's first syringe services program in Reno, Nevada. Although Change Point has an official designation to provide sterile injection supplies, safe sex supplies, education, and HIV and hepatitis C testing, it also provides a radically inclusive social space for various individuals existing on the margins of Reno life. This project focuses on the ways in which staff, volunteers, and consumers create and maintain a socially inclusive space while drawing upon harm reduction discourse. Drawing upon the work of Michel de Certeau, as well as literature on spatial justice and third space (Oldenburg 1989, Soja 1996), I argue that various actors construct, maintain, and (re)define a meaningful space beyond the public health discursive framework of harm reduction and provide social support to one another while contesting notions of stigmatized identities.

### *Acknowledgments*

This project is dedicated to “Pamela,” who passed away the summer of 2016.

“Pamela” was a profoundly intelligent and beautiful person. She was a software engineer who lost her job during the recession and slowly lost everything, including her home. She is you. She is me. She will be greatly missed in our community and I will never forget her tenderness and sweet insights. Travel well, “Pamela.”

None of us can get through this life without the help of others. I am so grateful for each person (and institution) that made this project possible. Having said that, the following accolades and thanks are by no means constructed in any particular order of importance—you all mean so much to me and I am grateful for each one of you.

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work, and raise a family. Let's never, ever do this again. To my beautiful children, thank you so much for being so patient and for being my cheerleaders when grad school had me down. Also, I'm sorry for reading and writing so much. I hope you all know how much I love you both and if you learn anything from your dad and I—finish school before you have kids. Love you to the moon and back.

One more remark on gratitude and I swear I'm done. Thank you to the universe that I was able to walk away from years of heroin addiction and homelessness. I am so grateful to be alive. Thank you to everyone who saved me, whether from overdose, or saved me by *seeing* me and being kind. To my comrades still dependent on substances or living on the street: I *see* you. I *value* you. I *love* you.

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*Glossary of Acronyms*

AIDS-Acquired Immunodeficiency Syndrome

CHW-Community Health Worker

FQHC-Federally Qualified Health Center

HCV-Hepatitis C Virus

HIV-Human Immunodeficiency Virus

HRO-Harm Reduction and Outreach

IDU-Injection Drug User

MAT-Medication Assisted Treatment

PWID-People Who Inject Drugs

SAP-Syringe Access Program

SSP-Syringe Services Program

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*Vignette: A Matter of Life and Death*

*This morning a woman overdosed in the lobby. She is purple from not breathing. I begin shouting at people to get out and after the lobby is clear (except for one client that is intent on remaining in his seat, silent) the door is locked shutting people out on the porch. I take the woman's pulse and attempt to move her from her crumpled wreckage on the stairs as staff members swirl around Change Point gathering naloxone and syringes. As "Darling" stabs the long needle through the client's pants, I continue pulling her down off the stairs to clear her airway. Another staff member prepares a shot and I rummage through a purse trying to find a name to match the lifeless purple figure on the floor. After gathering a name from the ID in the wallet, I get back to the client. She has a **name** to call out. A "code blue" must have paged the clinic through the intercom system because during the commotion, nurses from the clinic come to assist and they take her saturation levels with a wireless pulse oximeter as another gets the portable defibrillator ready. The client's oxygen levels were extremely low—but she is now breathing. It took four shots of naloxone and defibrillation to get her back. She makes eye contact with me as I call her name out. "Stay with me Heather (pseudonym)!" I shout. I tell her the ambulance is on its way. Shocked and frightened, she attempts to get up hastily but falls back down. She is afraid like most who overdose that the ER will treat her poorly. Stigma prevents many from seeking help. The paramedics arrive and medical information is passed to them. They strap her on the gurney and with tears in her eyes she blows kisses. I quickly run around picking up the used syringes and vials and disposing of them in the biohazard and sharps bins. The lobby opens back up for business as usual.*

Journal entry August 31, 2015

Update: The woman in this entry survived a polysubstance overdose thanks to naloxone and the many helping hands that day, however, two weeks after this incident "Heather" died from an overdose at her home. "Heather" was a daughter, a mother, and a wife. I dedicate this thesis to "Heather" and the millions of opiate dependent individuals like her. Naloxone is tremendously important as "dead addicts don't recover" and most certainly, dead addicts do not get to write theses.

## Chapter 1—Introduction: Research Site and Methodology

*“Neither the life of an individual nor the history of a society can be understood without understanding both.” C. Wright Mills*

“Unkempt,” “unsightly,” “derelict,” “condemned,” and “abandoned” are all words used to describe urban decay. It is unsettling that they are also adjectives used to describe the individuals most often found in such urban landscapes. Their common tragedy is the insufferable neglect that has forced them both to the margins of urbanity. I chose to focus on these neglected spaces of the city I was born in. Specifically, I situate this project in a syringe services program (SSP) called Change Point that offers HIV and hepatitis C testing, while unofficially acting as a drop-in center for the houseless and addicted. While this project touches on the stigma and marginality of addiction and homelessness—two separate experiences that sometimes converge—the key aim of this thesis is to analyze the ways in which various actors within Change Point understand the “harm reduction” model and work together to create a socially meaningful space for a largely excluded subset of the community. For community health centers, social services agencies, drop-in centers and others offering services to the marginalized, excluded, and underserved, this project serves as a template of what radical inclusivity can look like within healthcare and addiction treatment, and how inclusive spaces can foster healthcare interventions for the vulnerable. Service providers and academics know that poverty, housing status, race, socioeconomic status and so many other social categories are social determinants of health. Arguably, stigma and lack of a positive social support network are also linked to long-term health and wellness. This project addresses the gaps in ethnographic literature

by addressing the ways in which a syringe services program, by definition a harm reduction program, can provide social support to local disenfranchised individuals through grassroots community building. For many people experiencing homelessness and for people who use drugs, environmental factors affect access to healthcare and the stakes are often life or death. As an anthropologist concerned with both the subaltern lived experience and daily practice, as well as institutional practices, policies, and discourse, this project is situated betwixt and between consumers and providers of health and human services. I aim to provide insight into the particularities of this space, the people who interact with it and within it, and the broader policies that shape it as well as provide a roadmap that links grassroots activism with public health policies to create health equity and spaces of inclusion within healthcare organizations. This project is timely, as overdose rates soar and the United States faces an opioid epidemic. The “war on drugs” has been a failure resulting in the U.S. having the highest rates of mass incarceration of any developed nation. Wealth inequality is increasing, homelessness is rising, and affordable housing inventory is shrinking. These issues face all Americans, not just Americans on the margins and we need to be discussing ways to make things better.

### Defined by Absence

Sometimes the calamities of one’s lived past are rendered visible upon the flesh like the scars of scorched earth upon a landscape—breathing into existence a certain visibility. Just as history is etched upon the lines on faces and scars on flesh, in a broader sense the same holds true for city streets in the form of sites of abandonment and urban blight. Histories are woven into the tapestry of the visible and hidden histories dwell only

in memories. This is true for the downtown area of Reno, Nevada and particularly an area known as the Fourth Street Corridor, which has come a long way since its heyday as a burgeoning railway route.

Today, the Fourth Street Corridor is best described by its scarcity. This area is known as economically depressed, food insecure, and is inhabited by people living on disability, the working poor, and people making a living through the black-market of drugs or sex work. It is defined by absence: absence of money, resources, food, and many services. This section of Reno has a long history of transiency that intersects with Nevada's history of divorce and the residency requirements to obtain a divorce helped to create temporary housing options ("Lincoln Highway Era" n.d.). Many of the motels that currently provide housing to the poorest Renoites ironically were born from an era of the post-WWII economic boom in the 1950s ("Postwar Prosperity" n.d.). The structures that once temporarily housed tourists increasingly began to become home to long-term residents seeking affordable housing options. Processes of gentrification and "urban renewal" ironically became urban blight, and forsaken and forgotten areas of town as industries and economics shifted over the years. The area has long provided a home to the working poor and an anchor for the unhoused community. As businesses collaborated towards a renaissance in the early 2000s, they banded together to ensure that a homeless shelter would not encroach into this corridor ("The New Millenium" n.d.). However, the Great Recession (2007-2009) hit Nevada especially hard, which caused a ripple effect on the housing market and hurt the poor the most.

According to University of Nevada, Reno sociology professor Jeff Mitchell, much of the real estate in Reno was purchased by out-of-state investors who revitalized

neighborhoods and raised rents, which set into motion the processes of gentrification and further spatial organization of the city to alienate the poor (Olivares 2015). Gentrification, along with anti-homeless ordinances that criminalize living outside and panhandling, the constant evictions from encampments in vacant lots, parks, ravines, riverbeds, and bridges, and hostile architecture<sup>1</sup> make it difficult to find a space of refuge. These processes have served to effectively limit the scope of homelessness to the vicinity of the homeless shelter that opened in 2007 on Record Street (in the Fourth Street Corridor). While there are many pressures to attempt to persuade houseless individuals to stay at the shelter, there is still a large population of individuals living outside in encampments, doorways, and in drainage ditches. It is mostly individuals not accessing the shelter and other services offered at the centralized campus that find anchor at Change Point (slightly west of the Fourth Street campus).

### Harm Reduction Discourse

Harm reduction, a model of understanding drug use and reducing drug related harm, arose as a reactionary response to HIV/AIDS and hepatitis C, and is considered a pragmatic approach that views drug use as a continuum between active addiction and abstinence. It is based on the philosophy of meeting addicts “where they are” as a strategy to attempt to reduce drug related risks and harms by empowering users to reduce risk in small achievable goals. It is this discourse that shapes the social space of the

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<sup>1</sup> During the summer of 2016, benches at the former city bus station were removed in Reno to prevent people from sitting or lying on them. In addition to removal of the benches, the planters were filled with jagged rocks and metal spikes surrounded the planters (Conrad 2016, Higdon 2016, Olivares 2016). Metal spikes, which are often used to keep pigeons from gathering on buildings have become commonplace to use against humans



Change Point Harm Reduction Center, my research site, which I will describe in a section to follow.

Harm reduction can be traced back to early methadone treatment in the 1950s and 1960s as the biomedical industry sought to intervene in opioid addiction with medication assisted treatment (MAT). The harm reduction discourse on syringe access and sterile injection supplies is a continuum between grass roots activism and public health or biomedical discursive arenas. The website for Change Point defines harm reduction as, “a philosophy and strategy that empowers individuals to reduce harm to themselves by 1) setting realistic goals and 2) validating any positive step or incremental change. Although Harm Reduction was initially implemented around drug use, it now has a wider range of applications, including sex, diet, health, and any aspect of self-care” (Change Point 2016).

Syringe access programs (SAPs) emerged from harm reduction discourse and first began as a form of grassroots activism that gained traction through public health and biomedical discursive arenas (Lane et al. 1993, Page 1997, Maté 2010). The concept of providing sterile injection equipment as a tactic to combat the influx of HIV/AIDS transmission rates amongst people who inject drugs (PWIDs) was a covert and dangerous practice led by activists like Jon Parker. Jon, a former heroin user turned public health Ph.D. student at Yale was arrested numerous times for engaging in clandestine needle exchange through street outreach (Szalavitz 2013, Kirp 2010). Later, groups such as the AIDS Brigade and ACT UP (Szalavitz 2013) worked to create syringe access in the United States—much later than the needle exchange programs that many European countries had implemented a decade before. In both the United States and Europe,

grassroots discourse has been largely coopted and subsumed by public health institutions, policies, and practices. SAPs are rooted in harm reduction discourse as the primary vehicle of action. Discursive practices and social practices have a bidirectional relationship and fuel each other through complicated sets of microinteractions and macrodiscourses—in other words, practices become policies that in turn, shape practices. It is through tensions between consumers, grassroots organizations and policymakers that have led to discussions, research, policies, and “best practices”

Anthropologist Miriam Ticktin states that, “radical change is the result of *political* action, not politics” (Ticktin 2011:19, emphasis in original). Many organizations have rallied against the War on Drugs, which has resulted in political action that has changed drug laws in many states. According to the Drug Policy Alliance, as of 2016 twenty-three states now allow the use of medical marijuana and four states have legalized (and are taxing) marijuana (“Drug War Statistics”). Organizations like the Drug Policy Alliance are calling for reforms “to reduce harm related to drugs—as well as harm caused by drug policies” (“New Solutions for Drug Policy” 2015). The World Health Organization (WHO) publicly supported decriminalization and advocated for harm reduction methods in their 2014 report (WHO 2014), and the Global Commission on Drug Policy echoed the WHO’s recommendations in their 2014 report. Former Mexican President Ernesto Zedillo, a member of the commission stated, “Consumption has been increasing. Prohibition has created a disaster, not a world free of drugs” (Ferner 2014). Collaborative efforts between law enforcement, court officials, non-profit agencies, and community members, like Law Enforcement Assisted Diversion (LEAD) in Seattle, are “transforming the national discussion about how to end the war on drugs and mass

incarceration” (Sayegh 2015) by creating a new process of helping addicts through “a highly coordinated, harm-reduction focused continuum of human services—including housing, counseling, job training, drug treatment, mental health services, and healthcare” (Sayegh 2015). Organizations such as LEAD not only affect the local treatment of addicts, but also affect policy in other locales as well as influencing broader drug policies. In Reno, the Mobile Outreach Safety Team (MOST) conducts outreach to unhoused individuals, individuals experiencing a mental health crisis, and those affected by mental illness as a crisis response team consisting of a social worker and a Reno Police officer. MOST also works collaboratively with social service professionals to get behavioral health services, housing, medical care, and with the specialty court system to place individuals living with mental illness or experiencing homelessness into programs rather than incarcerate them.

Historically, the federal government in the US has generally not supported harm reduction efforts like syringe access programs (SAPs). In fact, in 2011 Congress reinstated a federal ban that prohibits federal assistance for SAPs (“Drug War Statistics” 2015) despite statistics from the Centers for Disease Control and Prevention that show SAPs lower HIV transmission among injection drug users by 80% (“Drug War Statistics” 2015). However, during the course of this project that ban was lifted as of January 2016.

Harm reduction is a simple approach that meets users where they are on the continuum from active drug use to abstinence. According to the Harm Reduction Coalition, harm reduction is, “a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs”

(“Principles of Harm Reduction” n.d.). Harm reduction strategies empower individuals to take charge of their actions to reduce harm to themselves and their community by reducing risks in whatever small or incremental ways as possible. Further, the Harm Reduction Coalition states that harm reduction “recognizes the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm” (“Principles of Harm Reduction” n.d.). In other words, they recognize structural factors that create barriers to safer injection practices.

The anthropologist Philippe Bourgois advocates harm reduction strategies, yet he critically addresses issues of efficacy in practice and indicates that many harm reduction outreach workers do not adequately address structural barriers (Bourgois and Schonberg 2009b). Despite the potential shortcomings, I suggest that harm reduction is the most inclusive and practical approach that seeks to eradicate drug-related stigma. The Harm Reduction Coalition offers workshops and curricula to address barriers of drug-related stigma between healthcare workers and drug users (“Improving Health Care with Drug Users” n.d.). Syringe access is firmly nested within the public health model, which posits that to minimize public health risk of infectious disease transmission, individual behavior must be modified as well. In this way, harm reduction is “both an expression of agency” and “a form of manipulation” (2003:13) as anthropologist Mark Nichter suggests. Anthropologists Robert Desjarlais (1996) and Susan Shaw (2012) have noted the ways in which biomedical and public health discourse becomes internalized at an individual level, however, actors engage with discourse for a multitude of motivations which are not often aligned with intended outcomes Varying motivations become particularly compelling

upon quantitative review as syringe access programs (SAP's) boast a higher incidence of unanticipated benefits (beyond reducing pathogenic risk) such as entering treatment or accessing medical care (Wodak and Cooney 2004).

#### SB 410: Discourse to Legislation

In Nevada, grassroots organization gained traction through coalition building to legalize syringe possession and distribution and remove hypodermic devices from Nevada's paraphernalia legislation. It took three legislative sessions to succeed, but in the summer of 2013, Governor Sandoval signed SB410. The coalition, at the time called the Public Health Alliance for Syringe Access (PHASA), now called the Public Health Alliance for Safety Access included: Northern Nevada Outreach Team (NNOT) and the Washoe County Health Department (WCHD). This alliance between street outreach organizations (NNOT) and public health institutions denotes the marriage between grassroots activism and governmental entities that work together to change policy at the local, state, national, or international levels. Changes at the policy level are enacted through organizations such as the State Board of Health which was tasked with establishing guidelines for SAP's that include disposal, education, and training of volunteers and staff. The first SAP in Nevada is Change Point, whose staff and volunteers are the individuals on the frontlines of providing direct services.

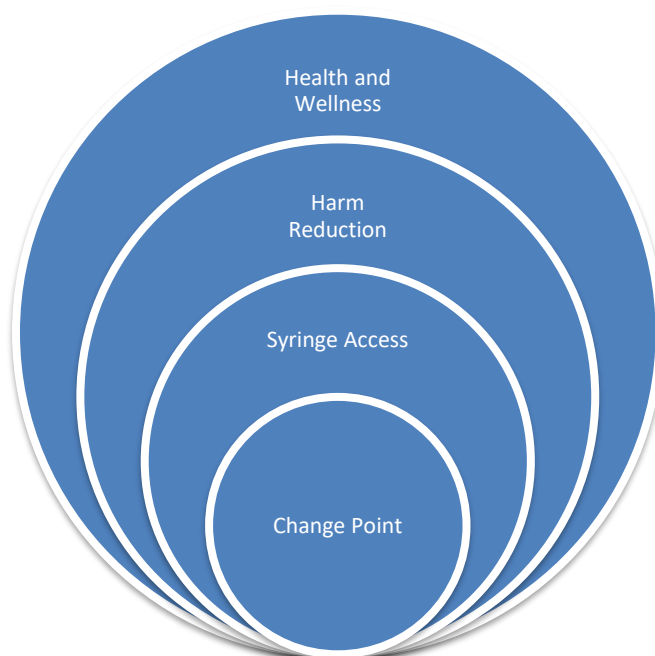
#### Research Site: Change Point

The reason I chose to discuss the research site at this point and not at the beginning of this chapter is a tactical decision. It is important to begin with a wide scope

and narrow the focus on the local context of Change Point for many reasons. The trajectory of broader movements, policies, and cultural shifts traces a path to legal syringe possession and distribution and chart the complex social and legal processes necessary for the birth of this particular syringe services program (SSP).

Change Point operates under the auspices of the Federally Qualified Health Center (FQHC) Northern Nevada HOPES (an acronym for HIV Outpatient Program Education and Services). Change Point is situated within the broader arena of syringe access, which is nested within harm reduction discourse, which in turn is situated within a larger conversation on health and wellness (see Figure 1.1). Historically, HOPES was a grassroots clinic dedicated to providing medical care, case management, specialty medications, rapid testing, and a drop-in center specific for individuals living with HIV/AIDS. HOPES began in 1997 as a response to the growing number of people living

**Figure 1.1**



with HIV/AIDS in the community expanded to include primary care, behavioral health, and case management for the medically underserved when it became a Federally Qualified Health Center (FQHC) in 2012 and a Patient-Centered Medical Home in 2013. The clinic provides wrap-around services<sup>2</sup> based on an integrative healthcare model. This medical clinic seems a fitting sponsor of an SAP that provides syringes, injection supplies (cookers, cottons, tourniquets, sterile water and saline), hygiene supplies, sharps disposal (and containers), and rapid HIV and HCV testing. State policy restrictions and Change Point's connection to a biomedical clinic affect the underlying discourse that runs through staff and volunteer trainings belies the governmentality of modern biomedicine.

Change Point and HOPES are located in an economically depressed area of Reno on the western Fourth Street Corridor. Various casinos, run down motels, and liquor stores surround the property. The area is characterized by sex work transactions, drug transactions, fights, homelessness, overt drug use, and visible mental illness. When I first arrived at Change Point, an old two-story house, next to another old house, a modular clinic in the background I walked past the lively crowd on the porch and found myself inside a living room with a volunteer at the desk. There were chairs in the living area turned lobby and I waited for the coordinator to pitch my project. I felt at home. These are my people and I knew that as an anthropologist (with lived experience) that it was important to tell their stories through an academic lens.

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<sup>2</sup> Wrap-around is a service delivery model that offers a team of clinical and non-clinical support services that collaboratively create, implement, and monitor client-centered services to improve outcomes and lives.

### Methodology

*“Theorists and methodologists—get to work!”* C. Wright Mills

I began volunteering for Change Point in December 2014. The process to volunteer required an application, a complex interview involving a set of questions related to knowledge of harm reduction, tolerance, drug use, sex work, and providing non-judgmental care to a very marginalized group of individuals experiencing homelessness, sex workers and people who inject drugs (PWID’s). The next step is an FBI background check (\$40), an orientation, stacks of legally mandated paperwork, and documented training sessions. My original research questions vanished under the gravity of what I saw, felt, and heard from participants that I interacted with. I shifted my questions away from “risk” and towards the social construction of space. I began my fieldwork in July 2015 after the Institutional Review Board (IRB) and HOPES Compliance Director approved my project’s design. In seven weeks, I conducted and recorded twenty-three interviews including nine consumers, six staff members, and eight volunteers. Following my research project, I continued to volunteer for several more months at Change Point, which allowed the opportunity to give back to this community and deepen my understanding of structural factors that affect community members. In December 2015, I accepted a position as a case manager in the clinic in which I was able to apply my anthropological knowledge while having the capacity to affect change in the lives of the community I cared so deeply about.

### Positionality

*“You never really understand a person until you consider things  
from his point of view...until you climb inside of his skin  
and walk around in it.”* Harper Lee



Climbing inside someone else's skin is impossible, even in deeply intimate ethnographic fieldwork. However, cultural logic becomes more salient to an individual whose roots grew from the same logic. Anthropology has a long tradition of "cultural relativism" and "reflexivity" to aid in our understanding of a researcher's role within the community of study. As researchers, we are always faced with the issue of positionality and what Linda Martín Alcoff calls the "crisis of representation" (Alcoff 1991-1992), which she uses to describe the complexity of speaking for another. Alcoff states, "a speaker's location [which I take here to refer to their *social* location, or social identity] has an epistemically significant impact on that speaker's claims" (Alcoff 1991-1992:7). This issue of positionality and representation is further compounded by what Lila Abu-Lughod calls "halfie" or "native" (Abu-Lughod 1991) anthropologists. My position in the field echoes Abu-Lughod's question: "What happens when the 'other' that the anthropologist is studying is simultaneously constructed as, at least partially, a self?" (1991:140).

At this point you may be wondering how exactly a graduate student of anthropology may find herself a "halfie?" in connection to a thesis project on harm reduction and a syringe service program that doubles as a drop-in center for individuals experiencing homelessness. Initially my project was a study of female converts to Islam in Tijuana, Mexico. However, due to concerns about safety, financial constraints and a whole lot of introspection, I abandoned that project to pursue a lead on Nevada's first legal syringe services program. I consulted with a retiring medical anthropologist, Dr. Marie Boutté, over coffee, who advised me to pay attention to things that come up in life as sometimes they manifest as an interesting research project. During our conversation,

she offered many examples of stories shared by others that turned into research. The name “Change Point” kept coming up in various contexts—even at a Queer Student Union drag show at my university—and after hearing its name several times I reached out to a neighbor and friend who worked there. After listening to his passionate monologue on harm reduction I decided to radically change directions.

As a former heroin user who was houseless (off and on) for almost a decade, the issues around harm reduction and safe injection practices struck a chord. After fourteen years clean, I pondered the many “needle exchange” programs in cities like San Francisco, Austin, and Seattle in which I myself had been a consumer. It seemed this was the ideal project and I quickly began studying “drug ethnographies” for my literature review (which are explored in the following chapter).

Positionality is a hot topic in healthcare, as more community health centers, behavioral health agencies, and resource centers incorporate peer support specialists and wellness coaches into their staff and the shift towards empowering consumers unfolds as a priority. The growing consumer movement<sup>3</sup> advocates for consumers to use their own voice to tell their story, rather than having someone else speak for them. This project is situated within this tension of who is able to speak for whom. As mentioned, I am a former heroin user with a history of sleeping on the streets, squatting in abandoned buildings, and experiencing the stigma that these intersecting identities bring. For me, it is important to not speak *for* others, rather to speak *about* others who are often silenced

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<sup>3</sup> The consumer movement began in the 1970’s as a civil rights movement for people diagnosed with mental illness. Consumer activists shifted inhumane practices in mental hospitals towards a peer support movement. The consumer movement also used a phrase from the disability rights movement, “Nothing About Us Without Us!” which means that persons affected by policies should have participation and input in creating said policies.

and marginalized. Furthermore, this work is about agents' understanding of harm reduction and their own words about harm reduction practices—the interlocutors are quite capable of speaking for themselves and this thesis intends to provide the space for them to do so.

Anthropology has a long history of reflexivity within our discipline. Reflexivity can be best summed up as a process of self-reference and self-critique that analyzes the ways in which a researcher can be influenced (and influence) by their subjective role within the community of study. In an earlier section, I referenced my position as an insider within this community by touching on two intersecting identities: homelessness and opiate addiction. The implications of my position as an insider, both corporeal (tattooed, scarred, etc.) and possessing linguistic competence in a shared repertoire relating to homelessness and injection drug use, gave me access, informed the questions I asked, and shaped my analysis in a way that other researchers may not have.

### *Observant Participation*

Volunteering enabled access to the community and an opportunity to build rapport with program participants (“clients”—also referred to as consumers in this work), staff, and other volunteers. In addition to the practicality of volunteering for this project, as a former unhoused woman and injection drug user, the experience of being a volunteer motivated me to draw strength from a stigmatizing past and to form bonds with marginalized individuals. I was not so much a “participant observer” as most ethnographers find themselves, rather I was much more of an insider and as such, it made more sense to use “observant participation” as an epistemological tool.

Observant participation (Wacquant 2000, 2002, 2010, Moeran 2007, Parkin 2016) is a qualitative research method in which the researcher, as a community insider, is challenged with the task of maintaining objectivity during the course of ethnographic fieldwork. Observant participation emphasizes participation as the primary activity and observation as secondary. Stephen Parkin (2016), who conducted his ethnographic work with PWIDs, used observant participation and describes it as “a ‘synergising’ component within a wider qualitative research toolkit especially when dedicated to inquiries of sensitive issues or ‘hard-to-reach’ populations” (2016:1). Using one’s own subjective experience as a heuristic device for unraveling the complexities of a marginalized population is problematic as there may be a tendency to miss certain features due to normalizing behaviors in a familiar environment (versus an outsider in an unfamiliar environment). This project uses respondent’s narratives in an attempt to acknowledge the crisis of representation and allow interlocutors to speak for themselves. Reflexivity and positionality also lend transparency to the process of observant participation by being forthcoming about my role as a volunteer while conducting research.

Loïc Wacquant introduced the idea of “carnal sociology” (2015), in which the embodied experience of research participation is unapologetically acknowledged. Wacquant states, “methodically deploying one’s body as an intelligent instrument of practical knowledge production speeds up the acquisition of basic social competency—the *operant capacity to feel, think, and act like a Whatever among the Whats*” (2015:7). Although I did not engage in drug use, nor did I go back to sleeping on the streets, the tattooed, scarred body I inhabit (along with the lexical repertoire of terms associated with drug use) served to grant me instant access to a community that I still feel

very much a part of. This insider knowledge proved useful during the overdose in the lobby, discussing safe injection practices, or assessing someone's abscess.

### *Collaboration and Participatory Action Research*

The research design for this project was a collaborative model based on Participatory Action Research (PAR) in which the researcher and collaborators work together towards creating change through reflective research. Initially, key staff, clients, volunteers, and I collaborated to create a project that would reflect what actually happens at Change Point and how central it was to people's lives as a community space. Fran Baum et al. (2006) describes PAR as a method that:

seeks to understand and improve the world by changing it. At its heart is collective, self-reflective inquiry that researchers and participants undertake, so they can understand and improve upon the practices in which they participate and the situations in which they find themselves. The reflective process is directly linked to action, influenced by understanding of history, culture, and local context and embedded in social relationships. The process of PAR should be empowering and lead to people having increased control over their lives. (Baum et al 2006:854).

As a collaborative project, interviewees constructed their individual pseudonyms and assisted in creating interview questions. Collaboration with staff, consumers, and volunteers was critical for this process to unfold the way it did. Collaboration with individuals and the organization to achieve the common goal of promoting harm reduction discourse was important to me as a volunteer, researcher, activist, and community member. The research questions unfolded because of this immersion and collaboration and I am eager to share my findings with all members of this community to

keep the conversation (and action) going. Further, although this is an academic project, it is important that the writing contained in this thesis remain culturally appropriate and understandable to an audience of community members. This work is meant to be shared with the interlocutors who donated their time, patience, and stories as well as the organization that granted me permission to spend endless hours asking questions, recording, gathering materials, and requesting data. To be clear, this project was intended to be a PAR project, however, almost all of the interlocutors (staff, volunteers, and clients) that participated in this project are no longer a part of Change Point. Following publication, this project will be synthesized in an executive summary and disseminated to the organization and participants in the project that I am able to locate.

### *Semi-structured Interviews*

At the time that I began my fieldwork, Change Point had over 2,000 unique clients in its client database. To become a client, a unique client identifier is created (by the client) using the first three characters of one's surname followed by the date of birth. The identifier that is created does not have to be the client's actual name or date of birth, rather, it is requested that the client uses an ID that will be remembered for future visits to avoid duplication in the database. Given the paranoia that oftentimes accompanies stimulant use, many clients refused this process. Nonetheless, the IT department provided me with the data containing basic demographic information upon request (see Figure 1.2). I compared this data to demographic information that I collected during my interviews with consumers (see Figure 1.3). I did not, however, collect this information

on the staff and volunteers as doing so could potentially disclose their identity and violate the anonymity I diligently protected.

**Figure 1.2**

<b>Homeless</b>	<b>Count</b>	<b>Gender</b>	<b>Count</b>
FALSE	1597	Declined	443
TRUE	1056	Female	863
<b>Total</b>	<b>2653</b>	Male	1309
*reported housing status for most recent SSP encounter		Other	1
		Transgender Declined	16
		Transgender F to M	8
		Transgender M to F	9
		<b>Total</b>	<b>2649</b>
<b>Race</b>	<b>Count</b>		
African-American	116		
American IN/Alaskan Native	73		
Asian	18		
Declined/Not Reported	701		
Don't Know	21		
Native HI/Pacific Islander	28		
Other	1		
White	1691		
<b>Total</b>	<b>2649</b>		
		<b>Age</b>	<b>Count</b>
		13-24	410
		25-34	1013
		35-44	556
		45-54	492
		55-64	233
		65+	28
		<b>Total</b>	<b>2732</b>

**Figure 1.3**

Knowledge content	SSP Data	Research Project	% of Community
Registered SSP Clients	<b>2496</b>	<b>9</b>	0.36%

Age Distribution	SSP Data	% of Community	Research Project	% of Project
<24	410	15	1	11.1
25-34	1013	37	1	11.1
35-44	556	20	3	33.3
45-54	492	18	4	44.4
55-64	233	9		
65+	28	1		
<b>Total</b>	<b>2732</b>	<b>100%</b>	<b>9</b>	<b>99.9%</b>

Race/Ethnicity	SSP Data	% of Community	Research Project	% of Project
Hispanic	141	5.1		
African-American/Black	116	4.2		
American Indian/Alaska Native	73	2.6	1	11.1
Asian	18	0.6		88.9
Caucasian/White	1691	60.6	8	
Declined/Unknown	723	25.9		
Native HI/Pacific Islander	28	1		
<b>Total</b>	<b>2790</b>	<b>100%</b>	<b>9</b>	<b>100%</b>

Gender	SSP Data	% of Community	Research Project	% of Project
Female	863	32.6	2	22.2
Male	1309	49.4	7	77.8
Transgender Declined	16	0.6		
Transgender F to M	8	0.3		
Transgender M to F	9	0.3		
Declined/Other	444	16.8		
<b>Total</b>	<b>2649</b>	<b>100%</b>	<b>9</b>	100%

Housing Status	SSP Data	% of Community	Research Project	% of Project
Housed	1597	60.2	2	22.2
Unhoused	1056	39.8	7	77.8
<b>Total</b>	<b>2653</b>	<b>100%</b>	<b>9</b>	<b>100%</b>



Various staff members of HOPES collaboratively constructed close-ended demographic questions. Semi-structured questions were open for further collaboration by asking each interlocutor what other questions would be important to ask. I asked different semi-structured interview questions to each of the three following groups (staff, volunteers, and clients/consumers) and were as follows (including participant created questions):

#### Staff

1. What do you do at Change Point?
2. How long have you worked at Change Point?
3. What attracted you to Change Point?
4. Can you tell me about your experience with harm reduction, syringe services programs, or outreach? (Either as a provider or as a consumer.)
5. What is stigma to you?
6. Thinking about stigma, how do you see the clients of Change Point?
7. What questions should I be asking you about Change Point that you think are important to ask?
8. What is your vision for Change Point's future?

#### Clients/Consumers

1. What services do you access at Change Point? (ex. food, company/conversation, HIV/HCV testing, syringe services, referrals, other.)
2. Are you employed? How many hours per week?
3. Do you ever exchange favors (ie. sex, chores, etc.) to help you get by?
4. What is your housing situation?

5. What would you describe your annual income level as? (ex. \$1-9,999, \$10,000-\$19,999, \$20,000-\$39,999, \$40,000+)
6. What is the highest grade that you completed?
7. How often do you come in to Change Point?
8. How did you learn about Change Point?
9. What does stigma mean to you?
10. Do you feel stigmatized or marginalized? If so, in which social contexts? Does this feeling change depending on where you are or who you are with?
11. How visible do you feel to people? Does this feeling change depending on where you are? How so?
12. What is your experience like at Change Point?
13. How does this place (Change Point) make you feel? Do you feel visible here?
14. Does Change Point feel like a community, or not? How so?
15. What does harm reduction mean to you?
16. Do you practice harm reduction? If so, how?
17. What is your experience with other syringe services programs?
18. What would the ideal clinic like Change Point be like? What services would it offer?
19. Do you have anything else to share?

#### Volunteers

1. How did you hear about Change Point?
2. What made you decide to volunteer here?
3. What were your thoughts about Change Point when you first came here?

4. What does harm reduction mean to you?
5. Can you tell me about your experience with harm reduction, syringe services programs, or outreach? (Either as a provider or as a consumer.)
6. What is stigma?
7. How do you feel about the clients of Change Point?
8. What questions should I be asking you about Change Point that you think are important to ask?
9. How has Change Point impacted your life or your future plans?
10. What do you think about the interactions between staff, volunteers, and clients?
11. Anything else to share?

I transcribed and coded all interviews according to thematic domains. There were two technical difficulties during the interviewing process, including the recorder being shut off to console a participant who began sobbing and when we came back to the interview, I failed to ensure the recorder was turned on rather than paused. Thankfully, I had taken good notes during this interview, although the transcription is not available in its entirety due to the circumstances. In another interview that lasted nearly two hours, recording ceased as the battery died and it was several minutes before I noticed and turned on my spare recorder. In addition to interviews, I kept a fieldwork journal, a log that tracked goals for the day and what I accomplished, and a personal journal.

For the analysis component, I analyzed the data and coded themes that emerged and identified repetitive keywords. After reviewing the transcriptions on paper, themes began to emerge, such as motivations of staff and volunteers to work in this space. These themes were highlighted, and repetitive terms emerged within the themes. In addition, I

conducted a word frequency assessment which allowed certain me to explore these themes. H. Russell Bernard's *Research Methods in Anthropology* (2006) became my primary reference book. Bernard states, "The heart of grounded theory is identifying themes in texts and coding the texts for the presence or absence of those themes" (2006: 492). What emerged from this project had little to do with risk, rather it focuses on the social meaning of space (more on this in subsequent chapters). I tried to code methodological ("M"), theoretical ("T"), and observational ("O") notes during my jottings in my fieldnotes, however, it was oftentimes difficult to find time to write while participating in the daily operations of Change Point. Most days I would sit in my car for an hour or so and write before heading home.

### *Ethical Considerations*

There were myriad ethical guidelines to be established with the Institutional Review Board (IRB) and Northern Nevada HOPES Compliance Director before the research could begin due to the nature of working with individuals who engage in a practice that is criminalized in the United States and highly stigmatized. HOPES, as a FQHC that offers MAT, substance abuse counseling, and behavioral health services (in addition to infectious disease and primary medical care) must remain compliant with the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations (CFR) 42 Part 2 which protects client confidentiality and prohibits disclosure of identity or private health information. Confidentiality and protecting research participants is also a hallmark of anthropological research. I maintain interlocutor anonymity and all personal identifiers (including staff positions) remain undisclosed.

I asked all participants to come up with a pseudonym for this project. Almost all pseudonyms were created by the interviewees, although a couple of them declined to create a name and so I came up with one that they approved of. Since I spent several months volunteering before I gained full-board IRB approval to begin interviewing, I began soliciting potential participants early, explaining what the nature of my project was, confidentiality, and what the process entailed. Transparency with participants was key to engaging in this kind of collaborative undertaking and I am sure that I sounded like a broken record at times. I became queen of the three-minute elevator pitch about my project to recruit potential participants.

Following IRB approval, I had the institutional green-light to begin officially documenting my daily experiences at the clinic and I was able to begin interviewing. I coordinated with staff about interview times so that we could find a space that the participant was comfortable to speak, quiet enough to record quality interviews, and avoid interruptions. Most interviews were conducted on the fly, with frequent interruptions due to the busy nature of this space. All interviewees chose to be interviewed inside Change Point in a private room even though they were given the option to be interviewed elsewhere. The choice to remain at Change Point, coupled with *all* interviewees' responses about the meaningfulness of this space spoke volumes about how Change Point makes people feel. I began each interview with full disclosure about the project and obtained verbal informed consent before convening to interview. Written consent was not an option as that process would jeopardize anonymity and confidentiality. In addition, I provided my contact information to each interviewee, should they decide later to revoke consent (in which case I would have deleted their

interview). So far, a year later, no one has revoked their consent. In fact, as I sit here typing this I contemplate how many participants have asked me when I will be finished with this thesis (so they can read it) and when they can come to my defense.

In the following chapter, I provide a brief history of drug ethnography and its relationship to applied anthropology. Qualitative research (and more recently mixed-methods research) has evaluated health disparities in underrepresented communities and help create healthcare equity by shedding light on the ways that individuals and communities understand health and well-being, as well as situating their choices within an environmental context. Furthermore, public health discourse has impacted the criminal justice system as well as addiction treatment, as both have shifted to a more nuanced understanding of addiction as an illness that requires a complex approach. We cannot incarcerate our way out of addiction.

Chapter Two also explores the theoretical lens in which anthropologists and other social scientists have viewed people experiencing homelessness, people who use drugs and others who are often relegated to the margins of society. The chapter also discloses how positionality can be used in a specific manner to engage in “pragmatic solidarity” (Farmer 2005) and with intentionality creates an “anthropology of the good” (Robbins 2013). The theoretical orientation of this thesis emphatically points to the importance of space and place, strategies and tactics (de Certeau 1984), and the role of heterotopias (Foucault 1967) in healthcare—especially for medically underserved populations.

Chapter Three analyzes the role that place has on individuals and the role that individuals have in creating a meaningful space. Chapter Four focuses on the strategies and tactics of various actors at Change Point and how their words and actions intersect

with harm reduction discourse. It problematizes praxis by a slippage of the agentic role of practicing an action oneself or instructing others to perform a certain practice. The final chapter concludes with the ways in which theory intersects with life on the ground and the implications on creating “best practices” that inspire a sense of responsibility and community in the healthcare world.

## *Vignette II: The Beginning*

*Yesterday, I began my volunteer experience at Change Point. After being interviewed by two outreach coordinators (the ones in charge), asked a series of questions, and after paying \$42 for a background check. I was approved to be a volunteer immediately, and my background check came back in two days. I began my volunteer experience reading a stack of materials and signing various legal agreements with Northern Nevada HOPES. I then helped schlep donated toiletry items in broken boxes from a shed containing bicycles, supplies, and boxes of random stuff like wigs and gaudy New Year hats. After sorting the toiletries by category to assist the process of crafting hygiene kits when small bags would be available, I got to “shadow” a friend who also volunteers there. I got to work in the exchange room, where all of the action really happens. CP collects data on users’ drug(s) of choice, age, living situation, HCV status, whether he or she has been tested for HIV or HCV in the past six months, if they pick up (needles) for others, and if they share needles. After entering a client ID into the system, I check the information from their last visit, how many needles they were provided, and how many they brought in. They are then asked if they have syringes and how many. If they are loose, they go into a large sharps container, if they are in a sealed container, he or she is asked to show that it is locked and the entire bucket is deposited into a large barrel. They are then asked what gauge is preferred, full cc. or half cc., long or short? Cookers? Cottons? Tourniquets? Band-Aids? Alcohol swabs? Sterile water or saline? Condoms (lubed, flavored, un-lubed, female, etc.)? Lube? Toothpaste? Hygiene kits? There are so many choices, and usually clients leave with a giant paper bag of supplies and new sharps containers. Most clients responded with gratitude, thanking us for the “good work” that we do. All and all, it was a great day.*

*The staff is full of really extraordinary people. CP is a space of no judgment, where stigma is erased and people are people. Each staff member owns him or herself, and is clearly dedicated to their work. Conversations are free from inhibitions, and not topic is off-limits or candy-coated like it is outside of these doors. It is a refreshing environment and I feel right at home in the culture of this office. I must also admit that before I met with the Outreach Coordinator to sign my papers, the volunteer at the front desk said that he knew me from somewhere.*

*“San Francisco?” I asked.*

*“No, from the east coast,” he replied.*

*I told him that I used to live in Wildwood, Cape May Courthouse, and Philadelphia; he told me that he is from Point Pleasant and he lived in Cape May. Turns out that he knew*



*my group of friends from New Jersey and he met me almost twenty years ago. This big world gets smaller and contracts with each interaction.*

Fieldnotes—January 21, 2015

## Chapter 2: Drug Ethnography and Theoretical Orientation

*“Collect them before you  
direct them.” –Dr. Gabor Maté*

In this thesis, I argue that individuals with stigmatizing identities are able to create meaningful social interactions and social spaces that draws upon elements of harm reduction discourse. This chapter situates this project within existing literature on marginality, drug ethnography, and socially meaningful space.

Alienation, marginalization, and social stigma have long been the topics of research in the social sciences from Émile Durkheim’s *Suicide* (1897) to Georg Simmel’s *The Metropolis and Mental Life* (1903). Scholars have been eager to explain the mechanisms of social inequality in myriad ways. In this chapter, I suggest that stigma is the core element from which all forms of inequality emanate. By drawing on the work of Erving Goffman, I argue that stigma provides a launching point for the discussion of actual and symbolic forms of violence. Furthermore, stigmatized individuals embody social inequality in ways that become key determinants of access to resources which ultimately creates a pathological relationship with disease and death.

The first section will explore two central theoretical arguments that encapsulate how inequities perpetuate marginalization and most specifically legitimize health disparities while criminalizing suffering and how strategies such as “pragmatic solidarity” (Farmer 2005:229) play a role in providing equity and improving health outcomes. Section two chronicles the history of how anthropologists have engaged in drug ethnography and what key factors have shaped methodology and theoretical influence over time, and examines how paradigm shifts within drug ethnography are

mirrored within the shifts of cultural anthropology more broadly. The third section focuses on how work with people who use drugs is situated within the shift towards applied or engaged anthropology. The concluding section discusses the role of strategies, tactics, space, place, and heterotopias have in healthcare and harm reduction and outreach settings.

### Suffering at the Margins

#### Stigma

In existing literature—from websites to pamphlets, print media, and scholarly work—on harm reduction strategies, illicit drug use, and disease, “stigma” is a term that often permeates the discussion. Stigma plays an essential role in understanding how exclusion, oppression, and structural and/or symbolic violence are created and maintained.

Sociologist Erving Goffman provided key contributions to the theoretical understanding of the role of stigma and its link to mechanisms of social exclusion and oppression in his seminal work *Stigma: Notes on the Management of Spoiled Identity* (1963). Goffman describes stigma as a characteristic that marks an individual who fails to conform to social norms and is subsequently ostracized or avoided. These deviations from normality are described as “abominations of the body” (1963:4) which include morphological or physiological difference, “blemishes of individual character” (1963:4) which describe behavior that deviates from social mores or expectations, and finally characteristics associated with race, ethnicity, religion, and nationality. Each of

Goffman's typological variants become internalized components of identity as well as intersect with forms of inequality. Goffman notes that that stigma *naturalizes* processes of dehumanization, he states: "we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often, unthinkingly, reduce his life chances" (1963:5). This legitimization of processes of discrimination in tandem with the dehumanized portrayal of individuals or groups naturalizes inequity and codifies exclusionary practices.

According to Goffman, "an individual's social identity divides up the world of people and places for him" (1963:91). When an individual becomes marked as different, the difference becomes somaticized and plays a central role in identity formation. Likewise, stigma can become spatialized by the individual through solidarity with others who share in this difference in the form of a sub-community (Goffman 1963), or through external mechanisms that politically spatialize bodies through social and physical space (Bourdieu 1999).

### *Stigma and the Dramaturgical Space*

Stigmatized individuals experience inequitable treatment by individuals, social groups, and experience severe consequences of structural violence that inhibit the ability to fully participate in what may be considered to be a "good life." Life chances become paralyzed by perceived stigma, which can lead to intergenerational impediments and multigenerational reproduction of social and economic disparities.

With stigma conceptually underpinning various forms of oppressive mechanisms, I would like to explore the intersubjective "relationality" (Butler 2004:19) and propose

that it is within divergent social spaces that individual identity is made and remade. The self is in a constant dynamic dialectic with the expectations of others, when that self is one in which a socially recognized stigma becomes inscribed in the bodily “sign vehicle” (Goffman 1963) or bodily *hexis* (Bourdieu 1977); visibility precipitates social exclusion. I propose that shifting and unstable categories of exclusion (based on media and juridical discourse) create new possibilities for spaces of inclusion. The embodied experience of navigating through social spaces is always fluid and generative—the “socially informed body” (Bourdieu 1977:124) is acted upon by the external but also acts upon the external, the subjective experience is experienced through the objective world.

Through exploring the relationships between stigma, visibility, and processes of social exclusion and inclusion, the process of systemic exclusion become visible through symbolic violence and structural violence. I am most interested in how these theories can provide insight into my own work with marginalized individuals (drug users, homeless, and sex workers) and what the specificities of social space can add to the understanding of structure, identity, power, visibility, exclusion, and inclusion.

Our experiences as humans are somatic, and social interactions become strained when one is marked as different. Of course, difference is socially manufactured and its fluidity is inextricably chained to fluxes of cultural norms and values. Our bodies are sites of power, politics, and ideologies which are negotiated as we navigate through social spaces.

When an individual becomes marked as different, social contexts play a central role in identity formation and shape and maintain the distinct binary of self and other. In this way, somatic experiences of individuals are lived out in the flesh but shaped through

our movements through social spaces. Our lives are intersubjective and relational. Judith Butler states, “Let’s face it. We’re undone by each other. And if we’re not we’re missing something” (2004:19). As we move through these spaces our body becomes constituted by others, “the body has its invariably public dimension; constituted as a social phenomenon in the public sphere, my body is and is not mine” (Butler 2004:21). As social beings, our bodies and, subsequently, our identities are constantly (re)constructed by others in social life. Moreover, Bourdieu asserts that social space is symbolically constructed and expressed through physical space (2000:135). Pierre Bourdieu states, “social space tends to be translated, with more or less distortion, into physical space” (2000:134) which illustrates the ways in which broader societal understandings of race and class play out across spatial boundaries of urban landscapes and social spaces.

Social context, which Goffman describes as the “setting” (Goffman 1956), and individuals engaged in interaction, which Goffman calls “players” (Goffman 1956), can determine roles and expectations of performance. The dramaturgical model (Goffman 1956) views culture as performance, and all social encounters call for each actor playing her/his complex role in relation to broader social and cultural scripts (according to class, race, gender, age, ability, etc.). Much of the information that is broadcast in social settings is embodied, information embedded within one’s appearance, yet much information is conveyed through subtle nuances of performance and controlled by one’s autonomous agency (gender performance, bodily movements, gestures, speech acts, clothing, mannerisms, etc.); acts of control over performative mechanisms are what Goffman refers to as impression management (1956).

Incongruities between appearance and expected behavior result in a breach of expectations, and these expectations are based on societal/cultural values and what constitutes normative behavior. Social encounters are defined by both dynamism and fixity: they are defined by rigid adherence to expected norms but are also fluid enough to account for agency and diversity. Social acts are generative by nature and reflect the complexities that Bourdieu described in his notion of the “habitus” which is the “internalization of externality and the externalization of internality” (1977:72). The importance of social contexts cannot be emphasized enough when it comes to stigma and the degree to which it is perceptible under the scrutiny of the audience’s gaze.

We are made and remade by our interactions with others. Our presentation dictates perception, and perception guides how others interact with us. Many sign vehicles (Goffman 1956:15) are beyond impression management, yet they relay imperative information about our ability to participate fully in social life and may impede access to opportunities. Stigma and social space are inextricably linked and have a direct relation to the life chances that are available as well as vital information about inclusionary and exclusionary social processes. Stigma marks the margins as less than human, and naturalizes the limitations of life chances, rights, opportunities, and full participation in love and life while also naturalizing suffering as an integral component of marginality.

In the context of this project, Goffman’s theories of performativity and stigma are particularly compelling given societal perceptions of mental illness, addiction, sex work, and homelessness. Visibility of one’s class, behavior, employment choice, or lifestyle may result in social exclusion, criminalization, or involuntary commitment. Spaces of

inclusion are minimal for those on the margins, especially inclusive spaces where one can speak uninhibited with programming that promotes reducing harm rather than moral model abstinence only framework.

### *Expulsion*

To unravel the complicated dimension of reflexivity between individual identity and spatial politics, Pierre Bourdieu's theoretical contributions help bridge the gap. Bourdieu's concept of the "habitus" describes the "internalization of externality and the externalization of internality" (1977:72). Habitus aides in the understanding of the bidirectionality between environment and individual identity. Bourdieu argues that the relationship between bodies and places results in a "*naturalization effect*" (1999:124 emphasis in original) in which places are divvied up according to concentration of capital (material, social, etc.) or absence of capital. This "political construction of space" (1999:129) keeps social classes apart in the form of affluent and impoverished areas such as "ghettos" in which power over spaces is asserted "as symbolic violence that goes unperceived as violence" (126). Structural and symbolic violence manifest into pernicious institutionalized practices that continue the cycle across generations.

To understand just how embedded exclusionary practices are within the American context, both the ghetto and the prison serve as examples of what Loïc Wacquant has called "peculiar institutions" (2000). Wacquant states that "the ghetto is a manner of 'social prison' while the prison functions as a 'judicial ghetto'" (2000:378). Wacquant's central argument focuses on the racialization of spaces through social, political, and economic historicity, bolstered by statistical evidence of ethnic and racial dimensions of



incarceration rates in the United States; however, spatialized politics is applicable to the discussion of substance use, health disparities, and the war on drugs which will be discussed in the next section.

Broader structural inequalities are enacted through individual somatic experience, which in turn reifies these patterns in a generative and reflexive social choreography. Anthropologists have often turned to Michel Foucault to understand how bodies become sites of politics and power. Foucault illustrates the significance of bodies—specifically how they are exploited economically, punished, disciplined, and politicized—in which “the body becomes a useful force only if it is both a productive body and a subjected body” (Foucault 1984:173). The “normalizing” forces of biopower subjugates individuals through various social institutions, and through stratification and segregation (Foucault 1978). In terms of public health, medical anthropology, and drug ethnography, the most compelling of Foucauldian concepts (besides biopolitics) is that of the “medical gaze” (1973) in which biomedical practitioners dehumanize subjects as pathological objects. In his lengthy historical analysis of the clinical space, Foucault acknowledges that the “medical gaze” often pathologizes the bodies of the poor. The consequences of viewing some bodies as “morally legitimate suffering bodies” (Ticktin 2011:11) and others “existence as a living being in question” (Foucault 1978:143) can sometimes mean exclusion as a social pariah, life-long suffering, or death.

Anthropologist João Biehl provides a useful analysis of social suffering and societal abandonment in his microethnography of one woman, Catarina. By detailing Catarina’s life within and beyond an institution, he is able to situate her subjective experience within a larger sociopolitical and medical context while contributing to the

theoretical understanding of the stigma of mental illness, and the process of social exclusion or “social death” (2005:52). Biehl’s work also has stigma as the core that emanates vast and far-reaching threads in the web of processes such as biopolitics, segregation, subjugation, and medicalization which foreclose all possibilities in individual’s lives—including that of their own humanity as they become “ex-human” (2005:186). Catarina’s life story peels back the layers of social forces complicit in her suffering—and the suffering of those who remain hidden within the shadows of invisibility.

Drug ethnographer Lee Hoffer provides understanding about Denver’s drug using subculture, exchange, economics, identity, social networks, and how the war on drugs is waged every day in the lives of many who face the challenges of stigma, incarceration, and death. Hoffer documents the social history of the homeless population in the Larimer area of Denver. The homeless population in this context was essentially thinned by numerous actors from various apparatuses of business and local government. Law enforcement hassled individuals through costly citations and arrests, public spaces were bulldozed and fenced leaving no space for the homeless to congregate, and even the shelters began to police activity through excessive rules that limited the amount of time spent in the shelter and prohibited loitering. These shifts of disciplining, punishing, and erasure of visibility served to alienate the homeless who could not flee and the drug users whose habits chained them to this space.

### Key Approaches in Drug Ethnography

The two theoretical components—stigma and embodiment of social inequality—discussed in the previous section can be seen as central to the history of drug ethnographies as well. Early anthropologists studied drug use in small-scale societies in the form of psychotropic ethnopharmacology and ethnobotany, which began to shift as social scientists increasingly focused on urban drug users. This move from remote tribal regions to domestic urban spaces mirrors the larger changes transpiring at this time within anthropology, as the discipline shifted from studying in former colonies to exoticizing marginalized “others” through endoethnography. The lengthy history of drug ethnography is beyond the scope of this paper, but it is important to note a few important paradigm shifts that have strongly influenced present-day drug ethnography and their linkage back to the aforementioned theoretical frameworks (for a full history see Campbell and Shaw 2008; Page and Singer 2010).

### Deviance

As a starting point for urban drug ethnography, there are two noteworthy ethnographers that arose out of the Chicago School in the 1930’s: Bingham Dai and Alfred Lindesmith. Dai was trained in sociology by a student of Georg Simmel. Simmel focused on urbanity and influenced what later became symbolic interactionism and social network analysis. Dai’s work, published in 1937, was based on his fieldwork and interviews with opiate users in Chicago. During this time, drug use had already become criminalized and thus shaped the American public’s image of drug users as criminals. In

addition, there emerged a racialized component to drug use as impoverished African-American neighborhoods—which were largely segregated from white communities—experienced an increase in substance use and addiction (Page and Singer 2010). Dai's work propelled a paradigm in drug ethnography that “contributed to the demonization of the drug addict as the ultimate deviant—the very embodiment of things strange and threatening to the dominant society” (Page and Singer 2010:38). The social deviance model of understanding drug use and addiction framed the research that emerged during this period of time. At the heart of deviance is the social stigma that attaches itself to drug users, marking individuals with labels and stereotypes that essentialize addicts as embodying what Émile Durkheim termed anomie (Durkheim 1897), a rupture between individual and societal norms, values, and expectations. Furthermore, during this time many social scientists were heavily influenced by theoretical understandings of alienation and society by Durkheim, but also Max Weber and Karl Marx who all approached the causes of alienation from differing perspectives.

The deviance model held tremendous influence over drug ethnography until after World War II, when other paradigms began to emerge. Alfred Lindesmith, also of the Chicago School, and a student of symbolic interactionist Herbert Blumer moved drug ethnography away from the deviance model. Lindesmith published his first paper on drug addiction in 1938, and later (1947, 1968) began to approach drug use through a “social theory of addiction” (Page and Singer 2010:43) in which he used an emic approach to understand addiction from the addict's perspective. His research unraveled the social complexities of drug users and he refused to demonize them in his work. Lindesmith became an advocate of amending drug policies in the United States and as a result he

became a target of government harassment (Campbell and Shaw 2008; Page and Singer 2010). Lindesmith's perspective on the social aspects of addiction helped to usher a paradigm shift that shaped drug ethnography of the 1950's.

### Subculture

The "drug use as subculture" (Page and Singer 2010:50) of the late 1950's birthed a canon of ethnographic literature that focused on the microsocial world of drug users not in terms of social deviance or pathology, but rather as a rich subculture that "can emerge that is as meaningful and dear to its participants as it is alien and repugnant to 'outsiders'" (Page and Singer 2010:53). The ethnographic literature that emerged during this time by researchers such as Alan Sutter (1966), Edward Preble and John Casey (1969), and Howard Becker (1963) brought to light the richness of drug using culture and challenged widely held public perceptions.

Howard Becker was publishing his classic *Outsiders* at the same time as Erving Goffman was writing about stigma. In this work, Becker used labeling theory to aide in the understanding of how the gaze of others through the use of labels such as "deviant," "criminal," and "mentally ill" serve to formulate self-identity and social structure. Becker, like Goffman, saw deviance as creating a form of social cohesion; he states, "once labeled as 'deviant,' people are inclined to seek out others who bear a similar social label, leading to the emergence of a deviant subculture" (Becker 1963:38). The subculture paradigm inspired many key drug ethnographers of the 1970's and early 1980's such as Dan Waldorf, Michal Agar, and James Inciardi, who began to add

important methodological contributions to both social science and public health, such as life-event analysis and multi-sited drug ethnography.

### *Risk*

The emergence of HIV/AIDS began a distinct and sudden shift in the ways that drug ethnographies were constructed and the importance of qualitative ethnographic work to explain epidemiological data. This shift in understanding the relationship between addiction and disease began to focus almost exclusively on risk. Epidemiology and ethnography, which were previously separate disciplines, converged at this time specifically because “ethnographers gain access to so-called hidden populations who might otherwise elude the normalizing gaze of public health” (Campbell and Shaw 2008:693). Ethnography became a useful tool for public health researchers as organizations were faced with a sense of urgency to find out what behaviors people were participating in on the ground and how to adequately address those risks.

The risk assessment model of drug ethnography emerged from the crisis of addressing the spread of HIV/AIDS, however, it can also be explicitly linked to funding sources and policy shifts towards an extremely morally conservative abstinence model enacted through the war on drugs. During the Reagan administration, the government became increasingly dedicated to eradicating drug abuse by criminalizing drug activity and “forbade the discourse and practice of harm reduction” (Campbell and Shaw 2008:694) as harm reduction was largely seen as immoral. This catalyzed a shift to “reposition harm reduction as an ethic of care—and drug users as ethical subjects” (694) which became apparent through ethnographic literature of this time that struggled to work

towards a harm reduction model within a political environment in which the Drug Abuse Act of 1988 prohibited federal funding of syringe exchange programs (needle exchange programs or syringe service programs) despite a growing body of evidence that HIV transmission rates dropped in areas where access to sterile injection equipment was available through needle exchange programs (Lane et al. 1993; Koester and Hoffer 1994; Page 1997; Campbell and Shaw 2008). In addition, agencies such as the National Institute on Drug Abuse (NIDA) was the primary funding agency for ethnography as a means to better understand population health from users' perspectives.

There are several methodological issues that derive from drug ethnography within the harm reduction model: labeling replacement, positionality within the field, and ethnography as a tool for governance. Pejorative labels that once permeated drug ethnographic literature like “junkie,” “dopefiend,” and “addict” were replaced during this era by labels defined under typological categories of behavioral risk. Individuals do not self-identify based on risk categories—or even as addicts as a key aspect of identity—rather individuals self-identify by ethnicity, gender, sexual orientation, occupation, as mothers, fathers, etc. Yet in popular discourse the merging of identities is often seen in labels such as “inner-city drug using Puerto Ricans” or “homeless drug-injecting youth” where behavioral categories arising from research have become normalized as “*techniques of governing* applied to the populations delineated by research” (Campbell and Shaw 2008:707, emphasis in original). This process of labeling serves to reify stigma and categories of deviance by shifting blame on individual behaviors while disembedding them from the sociocultural contexts that shape the decision-making process.

Researchers working within the syringe services programs tend to be associated by participants as conduits of the goals of such programs, in addition ethnographers are seen to be motivated by academic interests, thus they are seen differently than many of the outreach workers who are often in recovery themselves and “embody norms of abstinence and harm reduction in a much more literal and personal way than ethnographers” (Campbell and Shaw:705). This positionality may mark ethnographers as outsiders and create unintended consequences of using ethnographers as “instruments of governance” (708) and surveillance of marginalized populations.

### *Holistic Approaches and Social Justice*

The ethnographic focus on risk deflects efforts to restore personhood for drug users which is essential to actualizing risk reduction. Richard Parker’s work in Brazil found that prevention programs and HIV/AIDS prevention programs that were enmeshed with broader social justice work were much more effective than programs that only focused on risk reduction (Campbell and Shaw 2008). The shift towards broader analysis that reflect Paul Farmer’s call for breadth and depth beyond the “ethnographically visible” (Farmer 2004:308) can be seen in current drug ethnographies that examine the structural conditions that create invisible suffering while acknowledging how history has a “direct and profound impact on the bodies of the vulnerable” (315). This section will focus on the ways in which three present day drug ethnographers have examined the residue of historical, political, and economic failings on the bodies of the stigmatized and addicted: Lee Hoffer, Angela Garcia, and Philippe Bourgois.



Lee Hoffer's (2006) work with two of Denver's heroin dealers and their cohort of associates chronicles the importance of a social relationships to a drug dealing network. The ethnography largely focuses on heroin dealing and using, but in the end, Hoffer turns his attention to the misery that is produced from addiction, including Kurt's death at forty-five years of age. Neither deviance nor risk contribute to Hoffer's understanding of heroin use, rather his analysis focuses on a heroin-dealing network as a complex adaptive system, while still engaging in a reflexive authenticity about the intimate relationships that were forged through the process of his two-year case study. Interestingly, Hoffer's previous research (1994) from a "NIDA-funded, HIV-intervention program aimed at reducing high-risk behaviors" (Koester and Hoffer 1994:100) focused exclusively on sharing behaviors, including "indirect sharing," as risks for HIV acquisition. Hoffer's work provides a compelling case to highlight the shifts taking place within drug ethnography that expanded the focus from risk to a broader understanding of how history affects individual lives.

Angela Garcia's (2007) work stems from her dissertation fieldwork where she returned to New Mexico and worked as an intake attendant in Nuevo Día, an addiction treatment center in the heroin addled Española Valley. Through deeply personal narratives, Garcia is able to illustrate the ways in which historical process of loss, ties to geography and place, gendered divisions, and identity politics have shaped drug use through time. Garcia challenges assumptions that heroin use is an urban phenomenon, and heroin users are a monolithic urban population, as her work takes place in a sparsely populated, remote, rural region which also has the highest per capita rate of heroin addiction that is most often manifested intergenerationally. Her work also critiques

current models of addiction, incarceration, and treatment that fail to achieve lasting results for individuals suffering from addiction.

Philippe Bourgois has gained considerable notoriety within the drug ethnography genre and his work has transitioned from the study of risk (1998) to crack dealing (2003), to longitudinal ethnographies among homeless heroin users in San Francisco (2004, 2009b). In Bourgois's early study about sharing behaviors and HIV risk, he found that sharing practices revolve around social contracts deeply embedded in what he calls a "moral economy" (1998, 2009b). Bourgois illustrates the importance of ethnographic inquiry that J. Bryan Page (1997) suggested is an essential component to addressing risk among injection drug users. He critiques the reliability of epidemiological surveys and "self-report interviews conducted outside their indigenous context" (1998:2329) which links back to Nancy Campbell and Susan Shaw's suggestion that interlocutors often misreport sharing behaviors in order to be perceived as an ethical subject to the ethnographer. Injectors repeatedly misreported sharing behaviors to public health researchers to make themselves appear less risky, and less humiliated or stigmatized. Bourgois argues that this misrepresentation makes data collected in this way meaningless, as it inadequately describes actual sharing behaviors and he makes an argument for participant observation as a necessary supplement to observe what homeless injectors *actually* do—which is only possible through creating trusting relationships with users. He notes, "in order to collect 'accurate data,' ethnographers violate the canons of positivist research: we become intimately involved with the people we study" (2003:13). Bourgois suggests that risks cannot be parsed out from identity and lifestyle, thus a holistic approach is essential to understand the harsh

realities individuals encounter and how other factors (dopesickness, jail, infection, etc.) take precedence over “risks.” This entire article on risk is meant to highlight the fact that “much of the problem with the data on HIV risk is methodological” (1998:2344) and suggests that public health research that focuses on epidemiological statistical factors completely removes any analysis of how power relations affect decision making.

Other work by Bourgois criticizes the war on drugs—including disparities in incarceration rates—and the healthcare system that fails the marginalized. He painstakingly peels back layers of power hierarchies that intersect with poverty, class, race, ethnicity, and gender, and the ways in which those on the margins navigate extreme poverty and segregation through alternative means such as drug dealing (2003), symbolic violence (2009a, 2009b), and “lumpen abuse” (2009a, 2009b), a form of symbolic violence the marginalized enact upon each other. The work of Bourgois reminds us that systems of power and subjugation are performed through the frailties of the human body. The addicted bodies that he discusses are acutely aware of the visceral experience of suffering simply by the very nature of embodying practices that chase fleeting euphoria and attempt to cheat the recurrent trauma of dopesickness. Many of the interlocutors have traumatic histories of violence and they reify larger patterns of domination through symbolic violence, actual violence, or self-harm.

### Anthropology at the Margins

The previous section discussed the link between emergent patterns and paradigm shifts in drug ethnography specifically, however, in the broader discipline of cultural anthropology, similar patterns of paradigm shifts can also be seen. The best way to situate

drug ethnography through the chronology of developments in mid-late twentieth century anthropology is by acknowledging remnants of symbolic or interpretivist anthropology and Geertz's call for "thick description" to adequately ascribe meaning to behavior by analyzing the contextual social structure and history coupled with a heavy influence from post-modern developments that emphasized reflexivity, positionality, and power. During the latter two decades of the twentieth century, anthropologists increasingly began to shift their interests away from "primitive" others and towards the subaltern or "the subject living in pain, in poverty, or under conditions of violence or oppression" (Robbins 2013:448). Much of the growing corpus of modern cultural anthropology focuses on suffering subjects in a "voyeuristic pornography of suffering" (Bourgois and Schonberg 2009b:9), however, anthropologist Joel Robbins suggests shifting our gaze toward an "anthropology of the good" (2013) in which stories of aspirational subjects who strive in the face of suffering are told. This project aligns with Robbins work in that the narratives reveal the ways in which marginalized individuals thrive in the face of structural oppression and what first glance, may be perceived as suffering.

### Theoretical Orientation

Although drug users are still demonized by the media as "rich sources of dramatic distraction, as negative role models who help define the boundaries of approved behavior, as sources of very cheap labor (in and out of prison), as evidence of the unassailability of dominant understandings and values, and as conveniently scapegoated objects of blame for an array of social ills" (Singer and Page 2014:22), there are ways that drug users are pushing back against this dominant discourse. This project is situated within

conversations about humanizing addiction and homelessness while focusing on the ways that people thrive and are able to build a strong community at the margins, despite being viewed through a lens of suffering as anthropologist Joel Robbins suggests (2013).

### *Spatial Politics*

The shifting instability of discourse constantly produces categories of exclusion, but this process is a generative one that also creates new possibilities.

Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its holds and provide for relatively obscure areas of tolerance. (Foucault 1978:101)

In the course of Western ideology, politics, legislation, and repression throughout history, and in relation to what we have witnessed within the past century, it is easy to see how processes of exclusion can create spaces of inclusion. For example, religious persecution led to religious freedom, denial of women's rights led to the Suffrage Movement, racial inequality led to the Civil Rights Movement, exclusion of LGBT people led to LGBT rights. Through each process of exclusion, rich spaces of social inclusion and thriving community manifested. Negative power is still power. That is, what is repressed, hidden, not spoken of, and excluded, gains its power in relation to that which attempts to bind it to the margins. "Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (Foucault 1978:95). Perhaps the key to achieving more egalitarian spaces in the modern world is realizing that there is no "outside" of power.

Powerless groups often create spaces of solidarity and community in the face of countless mechanisms of oppression. Loïc Wacquant notes (from scholars Donald Clemmer, Gresham Sykes, James Jacobs, and John Irwin) that,

the incarcerated develop their own argot roles, exchange systems, and normative standards, whether as an adaptive response to the ‘pains of imprisonment’ or through selective importation of criminal and lower-class values from the outside, much like residents of the ghetto have elaborated or intensified a ‘separate sub-culture’ to counter their sociosymbolic immurement. (Wacquant 2000:384)

Likewise, similar cooperative communities of homeless addicts have been described by Philippe Bourgois as, “a community of addicted bodies that is held together by a moral economy of sharing” (Bourgois 2009b:6). Could these moral economies be situated within healthcare settings? Could spaces of inclusion be carved within this setting? How does creating a thriving community of disenfranchised individuals affect long-term wellness?

### *Towards Social Geography*

Initially, this project was framed by questions relating to harm reduction, visibility, and stigma, however, the data shifted this project toward spatial justice, heterotopias, and third spaces. In his paper, “Of Other Spaces: Utopias and Heterotopias” (1967), Michel Foucault uses one’s reflection in the mirror as his metaphor for these spaces of otherness. The reflection you see is a “you” that does not actually exist, but it shapes the way you relate to the reflection. He describes two central categories of heterotopias: crisis heterotopias (boarding schools, military schools, etc.) and heterotopias of deviation (prisons, rest homes, psychiatric hospitals etc.). Heterotopic

spaces or “third spaces” (Bhabha 1994, 1996, Soja 1996) are defined by their compartmentalization of spatiality and temporality. Other theorists (de Certeau 1984, Lefebvre 1974, Soja 1996, 2010) have also described spatial politics, which is where the data from this project conjoins with theory. This project shifts the focus from paradigms used to construct other drug ethnographies to the role strategies, tactics, space, place, and third spaces have in healthcare and harm reduction settings, which fills a gap in ethnographic literature about people who use drugs. The following chapter explores, in greater detail, the differences between physical place and social space and teases apart the ways in which various actors within Change Point work to create a radically inclusive space for people excluded elsewhere.

*Vignette III: Medicalized spaces and subhumanization*

*“You know, I never used to [feel stigmatized] but **now** that I’m homeless...I mean how do you get kicked out of McDonald’s? They don’t like homeless people there. The one over here south...west of town. So yeah, we got kicked out of McDonald’s even though we paid and did everything fine. I mean we don’t even talk to anyone when we’re in there. They still kicked us out and told us we couldn’t come back. It’s amazing!”* –“Pamela” is 42 and unhoused

*“I think what was lacking in Reno was a place that was welcoming and judgment free for **anyone**, no matter where they are or what their path is in life. And Change Point is...is **that** place. It doesn’t matter who you are, or what you’re doing, you’re welcome and accepted and there’s not going to be pressure for you to make changes. And you just...what I want it to be is a place where people have a sense of community. I don’t know that we’re there yet, but it’s...I want it to be a **community**.”* –“Zoë,” staff member at Change Point

*“And so to me it’s this double entendre where it’s not only where you’re coming to exchange your points but it’s also a place where you might have a changing point in your life. So it gives you the possibility to transform and transition—reinvent yourself.”* –  
 “Darling,” staff member



### Chapter 3: Carving Spaces of Inclusion

*“Their story begins on ground level, with footsteps.  
They are myriad, but do not compose a series.  
They cannot be counted because each unit has a  
qualitative character: a style of tactile apprehension  
and kinesthetic appropriation. Their swarming mass  
is an innumerable collection of singularities. Their  
intertwined paths give their shape to spaces.  
They weave places together.”*  
–Michel de Certeau (1984:97)

The media has fueled the social imagination of drug users, compounded by the criminal justice system and the biomedical industry to relegate people who use drugs to the social margins to the point of turning individuals into what João Biehl calls “a lived *ex-humanness*” (Biehl 2005:90). Many stigmatized populations have suffered at the margins of exclusivity at the hands of state controlled segregation, structural violence, and systematic expulsion (Biehl 2005, Alexander 2011).

The logic of governmentality lends primacy to criminalization of addiction and mental illness as cities attempt to control drug use and homelessness while treatments that are considered cost effective constantly shift and are underfunded. Suffice to say that this distorted logic has fueled overfunding of enforcement of laws and a public discourse that sees drug users as criminals rather than individuals that are systematically oppressed by structural forces that enable them to fall through the cracks rather than providing care and treatment.

Societal attitudes shape views about which groups are humanized and which are dehumanized and constantly shape or reinforce which attributes are viewed as stigmatizing. Many stigmatized groups have found their way into the human category

within the social imaginary by organizing to create a counterdiscourse that is first achieved by creating spaces of inclusion, or counterpublics (Warner 2002). An example of this, as Nancy Fraser (1990) and Michael Warner (2002) discuss as the history of the feminist and LGBT movement. I suggest that despite societal judgements about people who use drugs (or addiction, in general), it is possible to move towards inclusivity by popularizing harm reduction strategies in biomedicine and policy through pragmatic solidarity, preferential treatment for the poorest members of society, and through creating enclaves of “third spaces” (Bhabha 1994, 1996, Oldenburg 1989, Soja 1996), which empower people who use drugs by offering the support necessary to reduce risks and create a sense of community.

Stigma and embodied social inequality are central to theories addressed in the previous chapter and are predominant elements of theoretical constructions during the deviance model and holistic approaches of drug ethnography. Stigma leads to “spoiled identity” (Goffman 1963), which subsequently gets mapped on to individuals and collectives of people through the gaze of others. Stigma is a social process that precipitates social dispossession in the forms of alienation, exclusion from public spaces, segregation vis-à-vis neighborhoods (ghettoization), limits access to necessary resources (employment, housing and shelter, healthcare), and forecloses the possibility of life. As J. Bryan Page notes, “the most difficult and important work in preventing drug abuse and HIV in these settings is to convince people that they in fact have a future” (1997:27). The consequences of stigma, especially within the specific context of drug use and street injection drug use, are embodied forms of social inequalities that manifest various forms of violence, infectious disease, and premature death. Methodological considerations such

as geographic breadth, historical depth, and scrutiny of power hierarchies (Farmer 2005) enables understanding individual behaviors *in situ* of their cultural context, while examining the ways in which structural violence shapes “risk.” It also takes examination of what Singer calls the SAVA (Substance Abuse, Violence, and AIDS) syndemic, which requires an exploration of the interrelations of forms of violence, substance abuse, and adverse health consequences such as HIV/AIDS, abscesses, infections, and hepatitis C.

This thesis, however, is not focused solely on the paradigms of drug ethnographies of the past. The data shifted away from categories of “risk” and “deviance” towards community building, striving in the face of adversity, and the social value of (re)construction of space. Change Point is a place; indeed, it is a certain kind of place defined by a certain kind of ideology. Moreover, Change Point is a social space created and maintained by the actors who engage with it on a day-to-day basis (including institutional and governmental actors). Specifically, Change Point is a busy hub of activity that ranges from people coming in for injection supplies, HIV testing, food, material resources, to “hanging out” and enjoying a conversation. I argue that spaces like Change Point challenge assumptions about drug use, homelessness, sexuality, gender, and sex work in America because participants create a thriving community in a beneficial social space. This chapter will focus on the delineation of place and space and the various actors who shape this third space and create a thriving community on the margins.

## Place and Space

### Place

Marginality is not an abstraction, rather it exists in places, social spaces, and most certainly to/in/around physical bodies. In the context of culture in the modern United States, poverty has a boundary and poor individuals are relegated to areas of physical places that are most often classified as “dangerous” in the popular imagination. This ghettoization (Wacquant 2008) of the urban poor exists on a continuum in Reno, Nevada, and like most urban places in the U.S. has intersections with race and class. De Certeau refers to these as “places in which one can no longer believe in anything” (1984:106). Structural inequality creates tangible stratification of physical places that carve out social spaces and spatial boundaries that parallel societal inequality.

In Reno, the Fourth Street Corridor has had a history of economic booms during prosperous eras, which gave way to collapse and abandonment as the street suffered in the wake of shifting economies and industries. Motels that were once luxurious temporary shelter to travelers on a highway trip soon became homes to the working poor, seniors, people living with disabilities, and those teetering on the brink of homelessness. Drugs, sex work, and the consequences of criminalization of these acts became defining characteristics of “this part of town.” The area around Change Point is dotted with casinos, weekly motels, one (of the three) hospitals in the region, heavy police traffic, drug activity, violence, and the “track”<sup>4</sup> where entrepreneurs of the street sell sex to paying customers. This corridor is inhabited by the most impoverished citizens in Reno;

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<sup>4</sup> “Track” is a common urban colloquialism referring to a street where prostitutes frequently walk up and down to find clientele.

individuals Marx and Bourgois describe as the “lumpen” and de Certeau refers to as the “‘waste products’ of a functionalist administration” (1984:94). During the course of this project, this area has been the target of gentrification which has displaced hundreds of individuals with no other housing options. Like many impoverished areas (Skid Row in Los Angeles, for example) many in the region have turned a blind eye to displacement of the poor, siding in favor of a “clean” and “safe” city through redevelopment.

At the time this research project began, Northern Nevada HOPES was in flux and experiencing an identity crisis of its own as it moved away from HIV centered care to the broader arena of primary care, behavioral health, and eventually pediatric care. HOPES, as it is known colloquially, opened in 1997 and moved its operations to several locations before finally moving to Ralston Street (Figure 3.1). So much has changed from the onset of my volunteer work (December 2014) to the time of writing (August 2016-October 2017) as HOPES moved its clinical operations from a horseshoe-shaped motel, to a module, to a 37,000<sup>2</sup> foot, three-story, modern medical facility.

Figure 3.1

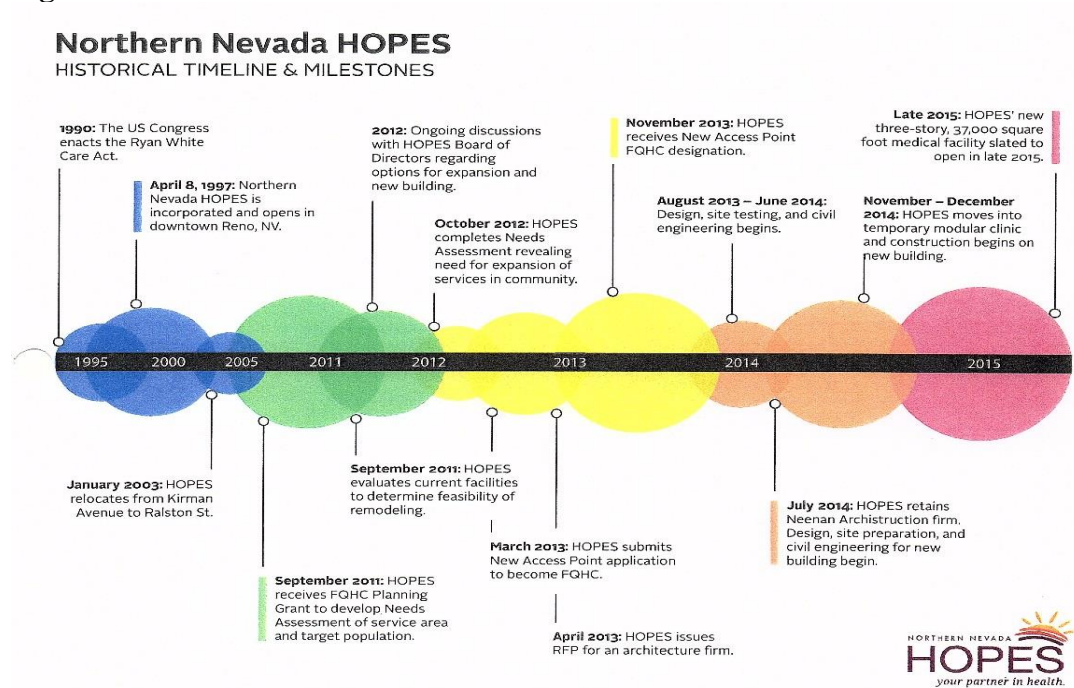


Figure 3.2



(National Register #83001118: Humphrey House in Reno n.d.)

For many years, the clinic was a U-shaped repurposed motel (“the horseshoe”) surrounded by the “HOPES House” and the “Hill House.” The “HOPES House” is where many of the staff had offices and was once the Humphrey House (Figure 3.2), a historic building built in 1906. The Humphrey house is a “two story stucco residential structure is Mission Revival in style” (National Register of Historic Places Inventory Nomination Form 1983) and was originally home to the Humphrey family. It later became a boarding house to individuals seeking divorce in Reno at a time when many people drifted to Nevada and needed to complete the necessary six-week legal residency requirements to obtain a relatively hassle-free divorce. The administrative staff, accounting, and social services moved out of the HOPES House in February 2016 and into the new facility. The Hill House (Figure 3.3) is

**Figure 3.3**

home to Change Point but once was a social hub for individuals affected by HIV to read, play games, use computers, socialize, and cook. The actual building was relocated from 445 Hill Street to its home on Ralston Street around 2001<sup>5</sup> to make room for the Nevada Museum of Art. Following the passage of SB 410 in 2013, which decriminalized the possession of hypodermic devices and created syringe access in Nevada, Northern Nevada HOPES repurposed the Hill House into Change Point—Nevada’s first syringe services program. Several longstanding clients who continued to interact with the space throughout its iterations, expressed their discontent at losing their HIV positive community space—especially to “those people<sup>6</sup>.” A few individuals expressed to me (in

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<sup>5</sup> I was only able to find the records for the home moving bid

<sup>6</sup> Many referred to “those people,” meaning the consumers of Change Point who were often viewed as “unworthy” and were often resented for using the space that used to be central to the social lives of people living with HIV/AIDS.



passing) that they did not believe that HOPES should be a part of such activity and told me that they avoided the area as it brought about too many “triggers<sup>7</sup>.” Their statements of discontent emphasize that though Change Point is an inclusive space, it is a contentious space.

Change Point is certainly a “place,” which Michel de Certeau discusses as a stable sort of fixed idealization created by intentionality of function. A place is “an instantaneous configuration of positions. It implies an indication of stability” (1984:117). The configuration of positions within this particular place are clinicians, executives, and board members of the FQHC, Community Health Workers (colloquially referred to as Harm Reduction and Outreach or HRO), volunteers, and consumers who access coffee, hygiene supplies, food, injection supplies, or HIV/HCV testing services. All of these subgroups draw upon divergent discursive arenas to create a distinctive social space. It was this “social space” aspect that affected the people I interacted with on a daily basis and the key element that I began to focus on.

Being a member (even a former member) of a community has its strengths, but it also most certainly has its drawbacks. For starters, I had “street cred” in the form of my knowledge of practices to identify and prevent overdoses, street medicine to treat nasty abscesses, safe injection practices, and even people within Change Point recognizing me by my street name “Turtle” from where I once lived in New Jersey. Sometimes, the great wide world collapses into a very small one. The drawbacks to conducting “native anthropology” research is that sometimes subjectivity stands in the way of objectivity and

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<sup>7</sup> A “trigger” is something (person, place, thing) that triggers a feeling of trauma and may precipitate an emotional or psychological response.

obscures the “strange” precisely because it is so “familiar.” Thankfully, there is space for reflexivity in anthropology, which is why I am self-disclosing throughout this thesis.

Self-disclosure is also an effective mechanism to challenge stigma.

Allow me to disclose a bit further to tackle why place and space became the central focus in this work. When I was unhoused, squatting, and injecting heroin—there was no public social space that welcomed me in. Even the mobile needle exchange programs did not offer sanctuary. In fact, since they were clandestine, they were often in alleyways where the police were waiting a block or so away, just waiting to criminalize another “addict” despite their efforts to be “safe” and “responsible.” Perhaps there were a few LGBTQ youth centers that tolerated my socially feral ways, but it was not the community that Change Point seems to be. As it turns out, I was not the only one who felt that Change Point was a special place. Staff member and former drug user “Angus,” who initially wished to be called “The Exception”<sup>8</sup> states:

It is a safe place, non-judgmental. I mean it’s just somewhere like I...I’m almost envious of the users who get to utilize this facility. And I’m like, “damn, I wish I had something like *that* when I was using.” And maybe you know, my drug use wouldn’t have progressed the way it did.

Change Point is a place that exists on a map (a first space, or actual space), on a street, within the Fourth Street Corridor, in Reno, Nevada and that was created because of changes to state policy, international public health discourses, evidence-based practices, and institutions. It is a place where, “a lot of directionless people find an anchor. You

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<sup>8</sup> “The Exception” was far too long of a pseudonym so I researched a name with that meaning and came up with “Angus” which means “exceptionally strong.” Angus approved of this pseudonym.

know a place to be when maybe they would otherwise be stumbling down Fourth Street or something?” (Interview with “Trainwreck” 2015).

### Space

Space, according to de Certeau “is a practiced place” (1984:117). He says, “stories...carry out a labor that constantly transforms places into spaces or spaces into places. They also organize the play of changing relationships between places and spaces” (1984:118). While agents like Zoë, whose comments on community appear on the page before this chapter, who occupies a position of power, actively work to create a sense of “community” through training Community Health Workers to operate Change Point as a particular place drawing on a particular discourse of harm reduction, “place” is transformed to “space” in a multidirectional and complex web of microinteractions.

Social spaces, just like physical spaces, are carved up based on models of stratification that exist within a culture and spatial arrangements are created, maintained, and recreated based on the broader hierarchical structures. People who do not fit within the established order of normative behavior are marked as deviant and stigmatized. People with stigmatizing attributes straddle normative and non-normative expectations, existing in the “interstices,” as de Certeau describes. He states, “if the delinquent exists only by displacing itself, if its specific mark is to live not on the margins but in the interstices of the codes that it undoes and displaces” (1984:130). The “interstices” seem an apt descriptor for the liminal space that Change Point provides to individuals whom local businesses often deemed unworthy to even use a public restroom.

The focus on spaces of inclusion and exclusion and which categories of bodies are included and excluded in these social spaces situates this project in what Edward Soja calls “spatial justice” (Soja 2010). The concept of spatial justice asserts that (in)justice may be mapped geographically through socially constructed spatial dimensions that attempt to cordon socioeconomic class, race, religion, poverty, and other socially constructed categories of difference. This bounded spatiality manifests in the *banlieues* of Paris, inner cities, and “ghettos” (Soja 2010, Wacquant 2008). Reno, Nevada has spatial pockets of poverty, wealth, the working class, middle class, Latinos, African-Americans, people living in abject poverty, and a centralized community of people experiencing homelessness (by the Truckee River and in the Fourth Street Corridor). In this thesis, I do not specifically focus on spatial justice, rather, I focus on the intersections of spatial (in)justice, the right to the city, contradictory spaces (Lefebvre 1974) and the creation of third spaces. However, spatial (in)justice is the seed of this endeavor, from which grows the heterotopic space or third space.

### *Third space*

Spatial politics, especially spaces of a public or social nature, have long been the topic of urban sociology, human geography, and anthropology. The houseless community in Reno has long suffered criminalization due to their houseless status, mobility issues (moving to evade police, individuals, and businesses, or lack of mobility due to possessions), public disdain, and more recently, hostile architecture that prohibits

congregation in public spaces. Houseless individuals and PWIDs are also human beings who have spaces of sociability just like their housed counterparts.

Ray Oldenburg, a sociologist, used the concept of “third places” (or third spaces) in his seminal work *The Great Good Place* (1989). His work focuses on the social life of urban dwellers, the third life, and the social spaces in which this sociability takes place. Oldenburg asserts that humans have a domestic life, a work life, and a social life and that spaces that enhance the latter have become scarce throughout time due to urban planning and suburban planning that have largely left out gathering places. For the sake of this particular project, it is my understanding that Reno has many options for spaces of sociability, however, these spaces exclude individuals experiencing homelessness and often, people who use drugs. Most social spaces in Reno are available as “hangouts” only to those who have the financial capability to pay rent in those spaces by purchasing food, beverage, or libations. The houseless are largely excluded from such establishments and are relegated to the margins of public buildings (libraries, courthouses, etc.), public spaces (bus station, parks, river bank, sidewalks), or the campus of the homeless shelter. Third spaces can be inclusive of the marginalized, as Homi Bhabha suggests, and Change Point “initiates new signs of identity, and innovative sites of collaboration and contestation” (Bhabha 1994: 1).

Bourgois described the compassion individuals had for each other in San Francisco’s homeless drug-using community as “the moral economy of sharing” (Bourgois 2009b), which is mirrored within the community (and smaller communities) at Change Point. Many individuals check on each other by visiting friend’s camps, bringing food to each other, sharing resources provided by Change Point, treating each other’s

abscesses, rescuing friends from overdose, and ensuring that others get medical care when needed. It is this rich social dimension that not only creates a sense of community, but it ensures the survival of many. Social groups often have central members and peripheral members who are often interlinked through a complex web of social networks. Social support is a matter of life and death.

The rich social network of peers converges on the old porch of Change Point each morning before they open their doors at 9:00 am. The lobby soon fills up with people and becomes a bustling hub of activity as people drink coffee, eat pastries, laugh, and talk. The volunteers and staff whirl past to refill coffee, tidy up, and get ready for the day's business. For the most part, despite mental illness (and sometimes severe mental illness), substance use and abuse, and differences of opinion, people are amicable in this space. However, my fieldnotes also record several occasions where fights broke out between consumers and on rare occasions, consumers would lash out at staff members. There was one individual who was permanently banished from HOPES during this project, however, this expulsion was a result after several attempts to resolve problematic behavior that nonetheless escalated to actual threats of violence against a behavioral health provider.

Notwithstanding very occasional episodes like this, Change Point is a sanctuary to the community it serves, particularly consumers. It is noteworthy that my fieldnotes documented the reactions of new staff members that toured Change Point during their orientation process. The onboarding process of HOPES requires that new staff members become accustomed to each department, meet the staff in those departments, and learn what the department does and how it fulfills the broader mission of HOPES. It was interesting to observe the anxiety levels and repulsion that dashed across body language

and micro-expressions of staff members as they completed their HOPES initiation process at Change Point. A sanctuary for some, but a stressful and chaotic environment to the novice. This also points to the difference between the clinic and Change Point as two very distinct places and different social spaces. It was also interesting to observe individuals (mostly students) who wanted to volunteer at Change Point. The staff and other volunteers would make it a point to observe the potential candidates as they waited in the lobby for their interview. Many would-be volunteers left. Many stayed with frightened expressions—and usually the fearful ones did not last long. Successful volunteers remained comfortable, calm, and accepting of the consumers who often struggled with mental illness, psychosis, and a lack of hygiene.

Change Point raises both hackles and eyebrows of visitors and clinical staff as several marginalized categories of people congregate in the parking lot (which often serves as a parking lot to shopping carts filled with belongings), the porch, and the lobby. A simple visual scan indicates that Change Point is a central space for Reno's vulnerable to assemble as well as an anomaly compared to other healthcare facilities in Reno's downtown core. These interstitial realms underpin both inequity in healthcare and a way to provide compassionate, stigma-free spaces within medical clinics. Change Point acts as a "third space" of sociability between the various actors who engage with this space. Its relation to its parent institution (an FQHC) and public health and biomedical discourse provides a unique access point for healthcare interventions. Change Point is a contradictory space (Lefebvre 1974) that creates community and inclusion through shared stigmatizing characteristics and destabilizes constructions of difference, exclusion, and wellness within its broader culture. Individuals who regularly find refuge at Change Point

may identify as homeless, a “tweaker” (a person who uses methamphetamine), a “junkie” (a person who uses heroin), LGBT, or a sex worker and many not regularly associate with persons outside of their social group, yet in this space, identities converge into an amalgam of marginalized identities which blur the lines between self/other and ingroup/outgroup. For example, white heteronormative individuals who expressed disdain towards transgender women, or people of color would suspend judgment and build relationships with black transgender women. This assemblage disrupts assumptions about homelessness, sexuality, and drug use.

### *Experiencing Stigma in Hospitals and Elsewhere*

*“If you’re with people who do not um, dress appropriately or they’re thinking that they’re dirty or they’re not ‘kept well’ they tend to look at you differently. I mean, they want to see you matching clothing, you know, clean hair and so forth. If you’re not then they kind of do look down on you. You can tell by the looks in their eyes. So, it’s kind of sad. You know, ‘cause some people can’t...I mean there’s not a shower out here. \*laughs\* You’ve got to find a shower.”*  
—“Pamela” (Interview 2015).

Medical anthropologists Merrill Singer and J. Bryan Page provide additional insights to how addicted bodies are treated in the medical industry in their book *The Social Value of Drug Addicts: Uses of the Useless* (2014). They describe a series of acronyms that were used by staff at the Jackson Hospital in Miami. Terms such as “SHPOS” or “Sub-Human Piece of Shit” and “AALFD” meaning “Another Asshole Looking For Drugs” were used to refer to patients in the emergency room (Singer and Page 2014:19). In cases like these, individual healthcare workers used creative linguistic



means to enact symbolic violence (Bourdieu 2000) in which daily interactions reify structures of social domination.

The homeless addicts that Philippe Bourgois and Jeff Schonberg befriended during their longitudinal ethnographic study in San Francisco (2009b) repeatedly encounter symbolic violence at the hands of emergency rooms, hospitalizations, and through well-meaning public health outreach workers. Moreover, many of these individuals were forced into inpatient treatment programs that offer limited success beyond detoxification. The structural conditions that precipitate drug use only become exacerbated by addiction, and healthcare practitioners, addiction treatment specialists, and the criminal justice system often isolate and alienate addicts, and further compound structural inequalities rather than addressing them. The biomedical community also acts as an apparatus of social control and another mechanism of exclusion.

Throughout the course of this project (and continuing through my current position), I listened to many stories about maltreatment within area hospitals. Narrative accounts of traumatizing encounters with nurses, doctors, and other clinical staff provided grisly details of the ways in which stigma becomes a silent killer. Societal perceptions (stigma) and criminalization of drug use is the reason friends often toss dead “junkies” in dumpsters, leave them in alleyways, and drop them out of vehicles on the hospital curb. Stigma and fear of legal consequences contribute to a reluctance to seek help for many addicts. Stigma is the reason treatable diseases and infections kill the houseless, the poor, and the addicted. Aside from the direct effects of stigma, “the widespread societal stigma of inferiority can create specific anxieties, expectations, and reactions that can affect health indirectly by having an adverse impact on socioeconomic

performance and mobility” (Fischer et al. 1996; Steele 1997 as cited in Hofrichter 2003). It is when stigma (which intersects with multiple identities) is internalized that intervention in healthcare becomes the most challenging.

One August afternoon, I met a heterosexual couple who met with me in the testing room to ask questions about suboxone (a medication used to treat opioid dependence), hepatitis C treatment, and how the female partner was treated at a local hospital recently for an abscess. Most clients of Change Point bond with a specific staff member or volunteer, who becomes a sort of case manager/counselor. This particular couple bonded with me and came back regularly to talk, to laugh, to cry. She reported that she told the hospital staff that an abscess was a spider bite out of fear that they would treat her poorly and take her children away. She said that after they became aware that it was an abscess, they began to “treat her like a subhuman” and even gave her spoiled food the day before she was discharged.

Another man told me about an abscess he had on his neck that was treated in the hospital. During this ordeal, the room filled with around thirty medical professionals, interns, and residents gazing in disbelief as his body became a spectacle.

Many of those who gathered at Change Point every day told various iterations of stories like the one above. “Trainwreck,” a local artist and painter, suffers a handful of medical maladies. Trainwreck, despite his physical issues and a body seemingly bowed by the weight of the world, is self-aware, intelligent, creative, and eloquent. When asked about the meaning of stigma, Trainwreck responded, “Stigma is when someone is outcast. When they’re made an other and they’re singled out because they’re different,

and treated poorly because of it. When questioned about feeling stigmatized, and if so in which social contexts, Trainwreck answers:

“No. I mean not in my life, generally speaking. Medical professionals, yeah. I am definitely... the medical industry stigmatized me because I am an addict. It’s only in the hospital. Everywhere else I’m pretty well respected for what I do. People like me and treat me nice, I think. And I try to be nice to people. I don’t really try, it comes pretty naturally. I want to be treated like other people treat ... you know, do unto others and that kinda thing.”

Stigma also permeates the core of healthcare and humanitarian aid organizations.

Foucault, in his *The Birth of the Clinic: An Archaeology of Medical Perception* (1973) describes the history of medical discourse and the “medical gaze” (1973) which currently dominates medical practice. Likewise, theoretical models of addiction often turn addicts into diseased persons (with no agency to resist addiction) or morally bereft persons who lack willpower (Fisher and Harrison 2013). The current dominant understanding in both healthcare and addiction treatment is the Biopsychosocial Model (Holmes 2013, Fisher and Harrison 2013) which incorporates multivariate factors that contribute to the complexities of addiction.

I do not mean to be overly accusatory of medical practitioners or addiction treatment specialists, I applaud their compassionate career trajectories, rather I wish to emphasize that “the lenses they have been given through which to understand their patients have been narrowly focused, individualistic, and asocial” (Holmes 2013:152). Miriam Ticktin suggested in her work with NGO’s that provided healthcare to immigrants in France that in order to be taken seriously by medical professionals (and subsequently the legal system), one had to be able to perform and be perceived as a “morally legitimate” suffering body (Ticktin 2011). Ticktin states, “the biological is

always mediated by the gendered and racialized narratives that allow certain people and bodies to be identified as morally legitimate, as worthy of being saved” (2011:19).

Other interviewees recounted their experiences of exclusion from other social spaces, including harassment in public places. Most expressed a desire for the freedom to be themselves, despite the limitations of social situations. “Richie,” a 43 year-old from the south, has traveled the world and gone from “silver spoon to the streets.” He says,

“But you know, I can’t even be who I really want to be most of the time. Because I’m just trying to get along, you know. And that’s because of your stigma. You know. I can’t even relax and be who I am because all these people expect *you* to act this way. And that’s not who I am. And it sucks. Because I have to conform somewhat from being who I am to being who they want me to be. And that’s not cool in my book... You know I’d rather be on the streets than to have to live somebody else’s life.”

Richie is not alone in his desire for authenticity and freedom from pressures to conform to cultural norms. He, like others I interviewed or had conversations with, do not feel like they fit in. Many feel invisible in many social situations, while others feel a hypervisibility that results in police harassment or visible public disdain. The result of the embodied trauma of navigating the world as a pariah is often anxiety, depression, alcoholism, and drug use. Change Point offers a refuge from exclusion and stigma. “Gigi,” a self-reported “homeless hooker” who received a BA in graphic design from an art school in the Bay Area and worked as a fetish model, describes Change Point as “this is where I feel safe. Where I feel like I matter.” Despite Change Point’s official designation as an SSP, many of the conversations that take place in the lobby involve discussions of recovery. Clients often discuss sobriety without being sanctimonious or shaming others. I have observed that such discussions are marked by their unwavering

lack of inhibitions, and many individuals comment on how anyone is able to discuss anything at Change Point. No topic was taboo within the space and conversations ranged from all forms of sex, sexuality, periods, exotic dancing, escorting, information about “bad dates” and an array of discussion on drugs and modes of use. It was a common occurrence in my fieldnotes that at some point in my day, I would be whacked with a large wooden phallus or spanked. The openness and safety that individuals speak of when discussing the affective nature of this space marks it as a space of authenticity and sociability. Change Point provides a counterpublic space—a third space for individuals who may experience negative social sanctioning in other spaces such as hospitals.

*Community Health Workers—How Peer Health Workers Challenge the “Medical Gaze”*

Grassroots community organizing has been an effective mechanism of fostering policy level changes as grassroots discourse becomes appropriated by public health discourse. For example, as noted in Chapter 2, syringe distribution in the United States was for many years clandestine activism. However, the movement towards providing sterile injection supplies to PWID’s began to gain traction among public health scholars and policymakers. This shift from top-down models of understanding and promoting health to a bottom-up model relies on community members’ lived experiences as expert knowledge rather than a white, middle-class academic understanding, which may view PWID’s within a rational actor model that assumes that PWID’s will make the optimal decisions to reduce harm to their health. Bourgois (2009b) asserts that this public health

understanding fails to take into account the struggles of meeting basic needs in the daily lives of houseless drug users.

The community health model is essential to promote health and access to services among the medically underserved by addressing social determinants of health and structural barriers that continue to impact health outcomes in minority and impoverished neighborhoods. Northern Nevada HOPES is an organization committed to providing integrative services and operating from the harm reduction model. According to their website: “For medically underserved populations, our one-stop-shop healthcare model reduces barriers to care and increases the likelihood of maintaining long-term health” (Northern Nevada HOPES 2016). The move towards integrating CHWs signals a policy and funding shift to include healthcare staff that “provide culturally appropriate health education” (Rosenthal et al 1998).

Following successful legislative efforts to make SB 410 a Nevada policy and providing a means for Change Point to become a reality in Reno, new positions arose to staff the SSP. Originally, their titles were “Outreach Worker,” however, during this research project those titles slowly slipped into “Community Health Worker.” As Squirrel states:

...it seems like the job title's changing but then when I saw the job description that came along with the...it doesn't seem like much about my job is gonna be changing except for the title. In fact, it seems like the community health worker...definition it may actually...it seems as if there's more emphasis in that definition as a community health worker...about serving...serving certain populations...populations that you may derive or identify strongly with. So...so...and that is I guess designed to facilitate leading people into care which is one of the primary purposes of HOPES as an agency, leading people who have traditionally faced barriers to care, getting those people into care. And so my...you know my core populations happens...that I work with...happens to be

injection drug users because you know, I run a needle exchange. So...so...it seems like the community health worker definition is focusing more on using those connections that you make in your core community that you're working with to build relationships of trust and...so you can advocate for them and so that they will...and so that you eventually will be able to link them into care and improve their quality of life and you know, cut down on the spread of death and disease and misery which is the...which is what we do here, you know. Which is for a public health worker, for an outreach worker that's I mean...that's what we do.

CHWs within Change Point fulfill all seven core roles and use their diverse personal backgrounds (sex worker, former injection drug user, LGBT, immigrant, etc.) to build rapport and trust through personal connection to experiences of the individuals they serve. This shift to the CHW model works to create a sense of “pragmatic solidarity” (Farmer 2005) and also shapes the space in which they conduct their daily operations. The overt identities of the CHW's that each proudly self-discloses, coupled with alignment with the clients they serve challenges the “medical gaze” (Foucault 1973) of the clinic. Rather than casting pathology on the bodies of the consumers who access this space, they form connection, rapport, and build on human relationships. This solidarity creates the trust necessary for individuals to not only get help when they need it, but to foster lasting change in their lives—in incremental steps.<sup>9</sup>

### Agents and Their Relationship to Creating Space

Places need no human activity to exist as coordinates on a map—a static dot between latitude and longitude. Spaces, however, are dynamic. They are constantly

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<sup>9</sup> These are the unanticipated benefits that Alex Wodak and Annie Cooney discuss in their illustrious research on SSPs that became a World Health Organization (WHO) white paper (Wodak and Cooney 2004).

(re)created by the individuals who inhabit them. They are temporally, spatially, socially, and politically arranged. The next section will focus on the multidirectional arrangement of actors that shape the space of Change Point directly and indirectly, laying the groundwork for the discourse analysis of the following chapter.

**Figure 3.4, Antique syringes are displayed in the lobby of Change Point (Lee 2015)**



**Figure 3.5, Pamphlets/Informational Brochures in the lobby of Change Point (Lee 2015)**



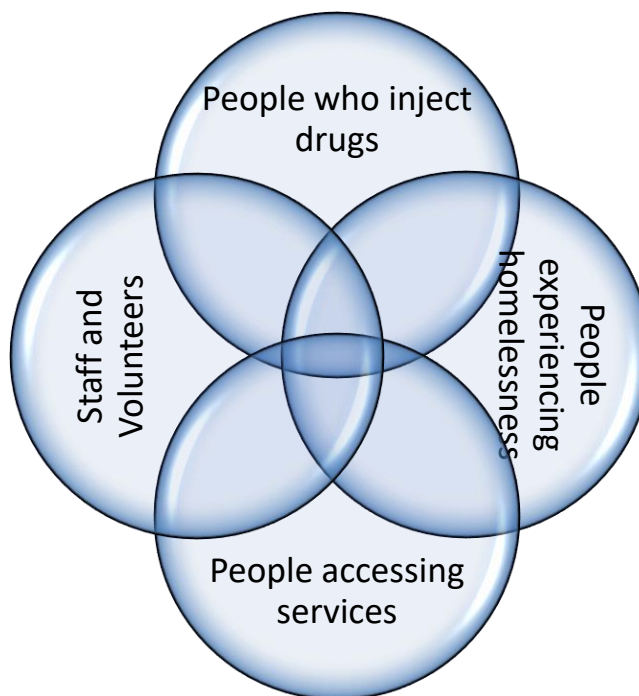


**Figure 3.6, Author posing with boxes of syringes and sharps containers in SSP room (Lee 2015)**



### *The Actors Within the Space*

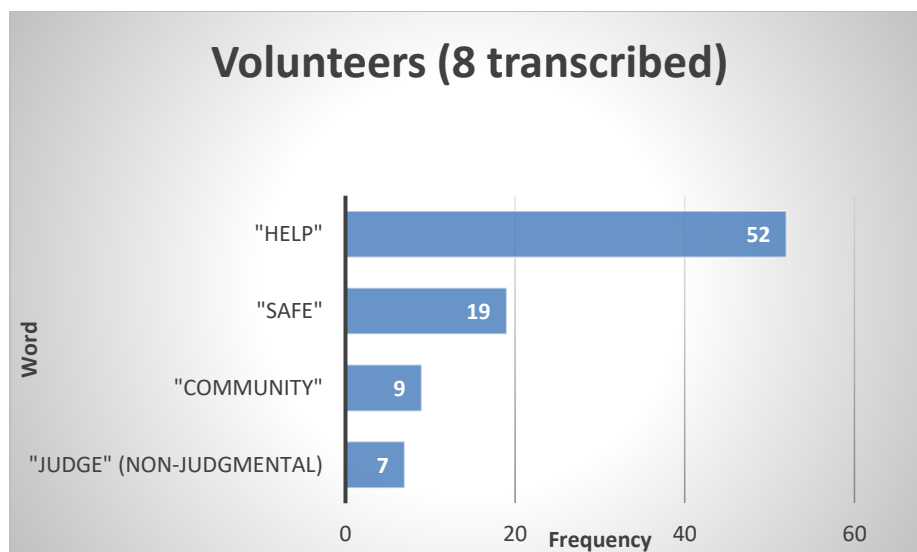
As discussed in the first chapter, Change Point came about from a union between policy level changes legalizing syringe possession and regulating their exchange, and a FQHC (Northern Nevada HOPES). The space is indirectly shaped by numerous actors (administrators, clinicians, Chief Medical Officer, etc.) and broader discursive arenas. Directly, it is shaped by the individuals who interact with it on a daily basis. For simplicity I have collapsed those categories into three distinct cohorts: clients/consumers, volunteers, and staff. However, the category of consumers could be further parsed into subcategories: people who inject drugs, people who are experiencing homelessness, and people who are accessing services (including coffee, pastries, food, testing, medical care, referrals, etc.). The categories often overlap (see Figure 3.7).

**Figure 3.7**

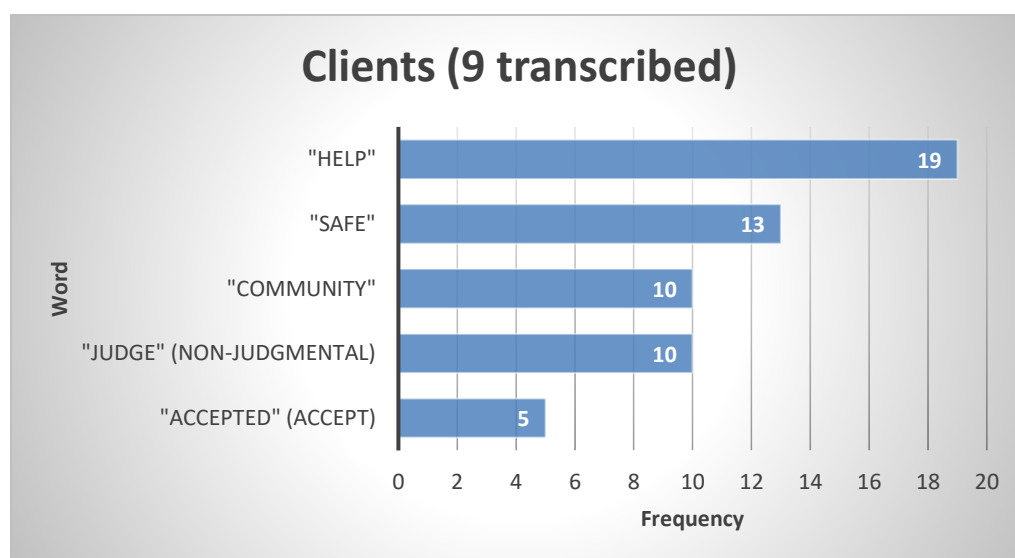
I chose to interview interlocutors based on their primary role within Change Point's daily operations and grouped them into three categories: volunteers, clients/consumers, and staff. During the design of this project, I lacked the foresight to ask questions about motivations of specific actors to come to this space, however, during interview transcription and data analysis, I noticed repetition of themes and keywords especially within and between cohorts. During the analysis portion of this study, I decided to perform a keyword analysis. Originally, I felt committed to use NVivo as a qualitative analysis tool, however, I used the keyword search in Word (which I used to transcribe 180+ pages of interviews). I identified themes such as motivations, understandings of harm reduction, visibility and inclusion, and community, while scouring over the written transcriptions and then noticed a pattern of repetition of keywords (help, safe, community, judge/non-judgmental, accept/accepted) within the identified themes, then I

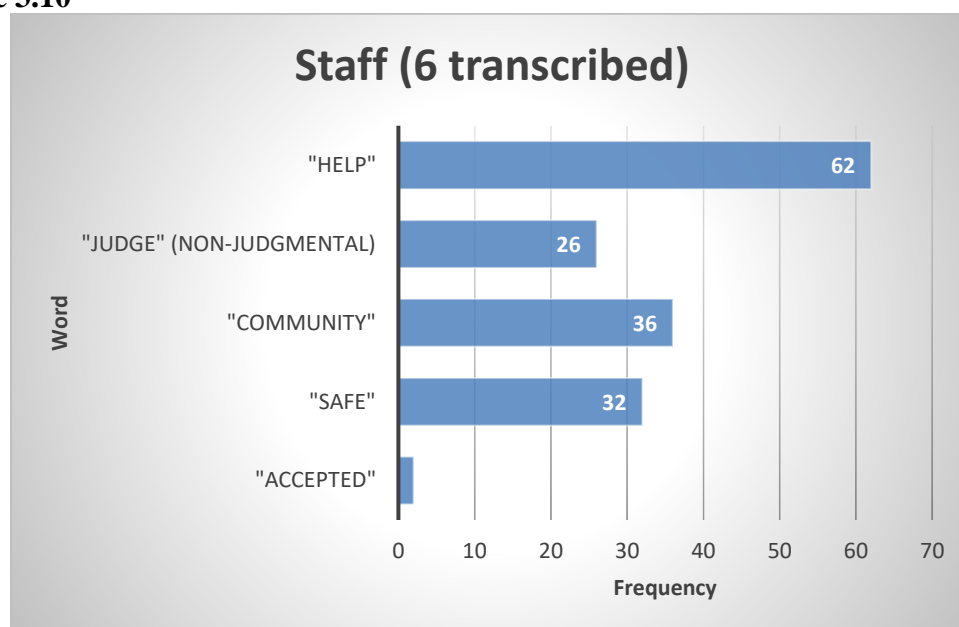
searched these terms in Word and counted their usage. I found the words compelling elements in unveiling the intentionality different groups brought to the space (Figures 3.8-3.10). It became apparent that there were themes that emerged organically from each group of interlocutors that unveiled the various intentions for coming to Change Point.

**Figure 3.8**



**Figure 3.9**



**Figure 3.10**

### Motivations

The motivations of individual actors who regularly engage with Change Point unfolded upon examination of word frequency within and between cohorts. Further, the cohorts had differing understandings of what harm reduction means (which is discussed in the following chapter). Change Point, in addition to its primary purpose of reducing the harm of injection drug use, is also touted by staff and clients as a “safe,” “non-judgmental,” place for the marginalized and medically underserved. According to staff member, “Darling:”

So, on our signs outside, you know, it says, “free HIV, hep C testing” but it also has a little catchphrase that says, “sex positive and substance user friendly.” So I think that those are really just kinda two of the core things that a safe space needs to have, for me. And so, you know I can say adjectives like “judgment-free,” “all inclusive,” “supportive,” you know, “compassionate.”

This commitment to provide a safe, accepting, community, free from judgment gains clarity from the usage of those terms in all cohorts. However, the most frequent term used was the word “help” and the differing relationships to this word across cohorts was intriguing.

### Help

Volunteers, despite a gap in their understanding of harm reduction (which will be discussed more in the next chapter) were motivated primarily by the desire to help others. Although their reasons for helping varied from having personal experiences with addiction or injection drug use, to watching family members struggle with heroin dependency, to coming to Change Point for an internship—they all proclaimed a desire to help individuals within this population. “Delirium,” a bubbly, gender-nonconforming psychology student with piercing eyes states, “I really like helping people and this like, I really wanted to work with at-risk populations. I like, wanted to get in there...metaphorically get my hands dirty. We wear gloves, so that doesn’t happen. ((laughter)) And uh...yeah, you know I wanted to do my best to help, and I did! Yay!” Others expressed a desire to give back, as they felt grateful that someone helped them. Volunteers like “Roxy,” a student and single-mother with brightly colored hair, reveal that volunteering time at Change Point is intrinsically motivated by personal experience. She says,

I used to volunteer at a long-term living home, a retirement home. And I really enjoyed it, but I didn’t like how I had to hide so much of my past of being a former heroin addict, and substance user, and being homeless and all these things that made me who I was. I had to hide that, and I didn’t feel that I could continue a career lying about who I really am...pretending

that these things didn't happen to me 'cause they're not socially acceptable. So, I really felt the need to be somewhere where I can shine and help people with the things I've been through.

Roxy is also motivated to challenge stigma, "I'm gonna be part of something. I'm gonna be part of a cause. I'm gonna help in whatever little way I can to make this adjustment in society to have things be more acceptable." Providing free labor in a stressful environment is a challenging endeavor, yet Change Point relies on volunteers to conduct its daily operations—without them it could not function. These factors act as a deterrent for volunteers who may not act in a non-judgmental and compassionate manner. In fact, staff members would keep potential volunteers waiting in the lobby to observe how they would conduct themselves amongst the clients before being taken upstairs to be interviewed. This process effectively "weeded out" candidates not motivated to help those whom the white middle-class logic has long classified as "the undeserving poor" (Farmer 2005).

Staff members are also committed to the ideal of helping and, due to their diversity, their narratives of how they help reflected each member's specialized knowledge. "Squirrel" an eloquent former heroin user (now methadone user), with a gift for writing, and a degree in Teledramatic Arts and Technology captures this perfectly:

But having the staff here, with you know with their trainings and their life experiences and stuff, when we have a situation where somebody is just damaging their arms are blown out, they're digging around they don't know how to get a clean shot and nobody in their life is you know... is trying to help them out. Or they're whatever the case...they're overdosing or they're... you know what I mean. They need more...they need a consultation and that's when the volunteer can come grab one of us and you know... Chad might be you know... if it's a hormone question, you know Chad might be the guy...the go-to guy. If it's a...you know if it's a question about you know poly-drug interactions or bad cut... or is this fucking abscess a serious problem, you know they might come and ask

me. And...and everybody learns. I learned from our volunteers every day. I learn from our participants every day.

Clients also discussed “help” but not in the same way that volunteers and staff did. Since clients are the primary recipients of the assistance offered by the other two cohorts, their narratives often conveyed the resistance many clients have. In the following quote, Richie captures this “service resistance” as well as the tension between clients that are less than open to the staff and volunteers who largely situate themselves in LGBTQIA identities.

I’ve seen some of the clients come in here and be obnoxious and just treat everybody like crap. But you know, I mean...but I don’t think they know how to deal with the gay thing, you know. I don’t think they have receptors for that. I don’t think they do. I mean, it’s stupid because you know they just don’t understand how helpful these people really are. All they do is see gay. And it’s like, it’s what it is. You know, I mean these people don’t have to be here! ((laughter)) They don’t have to come here and help your sorry ass. So you might want to be nice to ‘em ‘cause most of them *are* volunteers. Almost all of ‘em are volunteers and they don’t get paid shit. And they come in here to help *you*, you dumbass. They don’t get it. They *don’t* get it. ((laughter))

The divergent ways of relating to “help” highlight the gap between helper and recipient and bring to light perceived stigmatizing attributes of the individuals providing services that clients may find objectionable. The possibilities of bidirectional judgments based on identities relating to gender, gender expression, sexual orientation, drug use, and homelessness provide compelling insight into Change Point as a counterpublic. Michael Warner draws his theory of a counterpublic both from Nancy Fraser’s use in feminist theory (Fraser 1990) and queer theory.

Fraser’s asserts that subaltern counterpublics situated as simultaneously parallel and oppositional to dominant publics. As such, they are spaces where

members of subordinated social groups-women, workers, peoples of color, and gays and lesbians-have repeatedly found it advantageous to constitute alternative publics. I propose to call these subaltern counterpublics in order to signal that they are parallel discursive arenas where members of subordinated social groups invent and circulate counterdiscourses, which in turn permit them to formulate oppositional interpretations of their identities, interests, and needs (Fraser 1990:67).

Warner draws on Fraser's concept and specifically applies it to the LGBTQIA community as subaltern counterpublics have been a safe outlet for LGBT individuals to find community and solidarity. What is ironic within the context of Change Point is the fact that many staff members, volunteers, and clients challenge gender binaries and heteronormative standards through corporeal practice and presence within this space. HOPES (at the time of this project) had several staff members and volunteers that identified as trans or gender-queer. The subaltern identities of those providing services is an important aspect of how this particular space is constructed, and becomes undone in narratives of individuals like Richie who asserts that clients see these non-heteronormative identities as challenging or problematic. It also points to the challenges of radical inclusivity within a space. Change Point is not just full of PWIDs, though it is an SSP, it is also a space for many others who walk through its doors, sit in the lobby, and build relationships.

### Community

Despite the challenges of various identities converging within this third space, "community" is often discussed by all cohorts. This theme seems to convey a shared meaning, unlike "help" where there were allusions to hierarchy, insiders/outsideers, and a



construction of categories relating to who “deserved” or would “accept” help. Consumers primarily used the term “community” to refer specifically to Change Point, however, occasionally this term was extended to discuss Change Point’s impact on a broader sense—the Reno community.

In general, the volunteer narratives in this project are the outliers in all areas. All of the discussions about “community” by volunteers referred to the world outside of Change Point. For example, in the following passage, “Alice” a bright university student with a familial relationship to heroin addiction, refers to the broader sense of a regional community rather than the micro-community within Change Point. She states:

in our community, I think there’s a lot of stigma about drug users and that’s something that’s really important for me to change, ‘cause like I didn’t grow up in like a poor disadvantaged family. I mean, it can happen to anyone. And I think there’s sometimes a stigma in a community that like only people who like don’t care, don’t have the opportunities and are kind of like ‘bottom-tier’ become addicted to drugs and that’s just so not true. And like, I think there’s also a stigma that like they could stop if they want to, like it’s their choice and it’s just...it’s not true at all. And there’s just like a lot of ignorance surrounding addiction in our community, and something that I think Change Point really helps to change. ((laughs)) But it’s still not like perfect.

While consumers focus on the endogenous community of Change Point and the volunteers focus on the exogenous community, staff members align with both. A portion of each of their jobs is to provide education and outreach to the community (in the broad sense), however, they all strive to build a strong micro-community. Darling, a talented staff member who carries a bulk of the responsibility for operations of Change Point, states:

we have a really diverse group of both community members as well as staff members and [distracted by phone vibrating] ...the...but...you know

a common thing amongst all of us...not you know...for the...I'd say like seventy five percent of the people that you know, are really passionate about being here have felt stigmatized and oppressed. Or...you know misunderstood or judged, or you know something at some point in time in their life. And so being here and being in a place that really celebrates that diversity and lets you individualize yourself. And you know...it's I...I mean I was at a very specific population health clinic where it was sex workers previously. But it was all different types of you know, sex workers whatever their occupation was, whatever their gender, or orientation blah blah blah. It's like that here too, even though it's not you know, sex work specific. Like, you know. Everyone's got their own story and their own little twist and I feel like we learn from each other as like staff and volunteers—as well as clients. As much as you know...they...my community gives me education just as much as I give education back to them. So, I just...I guess Change Point just...it's a place for second chances...or fourth or fifth or twentieth or whatever. It's a place that promotes possibility. You know. HOPES was not named 'hopes' because...I mean it was probably catchy but it *stood* for something. It was 'HIV Outpatient Program Education Services,' previously. In fact on some legal documents, it still says that. But now we're just 'HOPES.' You know cheesy as it is, we could all use a little bit of hope sometimes. Like, you know? So I want...I want to instill that possibility for HOPES in all my community members.

Darling vacillates between using “community” to describe the clientele of Change Point (in the above narrative) and in other portions of the interview, she describes the importance of her work in “the community.” The use of the word community is relevant especially at this time of transition of job titles at Change Point.

### Internalizing Narratives of Hierarchy

Most consumers who frequent Change Point tend to get along well inside the lobby, on the porch, and in small cohorts in the parking lot, yet despite the intentions of staff, administrators, and volunteers to create an egalitarian, stigma-free space, there exists a far more nefarious system of inequality observed among consumers. In conversations and interviews, many consumers expressed disdain for other consumers

that shed light on the ways in which narratives of social hierarchies become internalized, embodied, and replicated. Pierre Bourdieu regarded this invisible hierarchy as “symbolic violence” (Bourdieu 1977). While this topic could be a research project of its own, I will only briefly touch on it here as it is imperative to acknowledge that though actors intend to create an inclusive space, hierarchy and exclusion are still present.

Just as people experiencing homelessness and people who use and/or inject drugs experience stigma and exclusion by structural violence and individual prejudice, often these processes are also perpetuated against others of other marginalized identities. In *Righteous Dopefiend* (2009), Philippe Bourgois described internalized hierarchies that he observed among houseless communities in San Francisco, and argues that they have ties to broader structural violence along racial and ethnic identities. He states, “they manifest themselves through everyday practices that enforce social hierarchies and constrain the life choices of large categories of vulnerable people, who identified in an essentialized manner as ‘races’ or ‘cultural’ groups” (2009b: 42). He further asserts that because of these structural hierarchies, microaggressions are legitimized. In the context of Change Point, which is largely comprised of white males<sup>10</sup> who suffer stigma and social exclusion due to housing status, mental health, or substance use, the racial and ethnic hierarchies are less apparent. Rather, in this context broader societal judgments on class, drug use (especially injection drug use), sexuality, gender expression, and mental illness are internalized and enacted as microaggressions towards other individuals in this space.

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<sup>10</sup> See demographic data, Figures 1.2 and 1.3

Many of the clients during the course of this research would mention their opinions about other clients in the space to me in private conversations. Their opinions were usually framed around drug(s) of choice and mode of transmission (smoking, shooting/injecting, etc.) or centered on resource allocation. There were also alliance networks and adversary networks that emerged from a wide variety of origins such as “doing time” with an individual, belonging to an adversary cohort (gang, motorcycle club, etc.), camp location, camp condition, drug of choice (“tweaker” versus “junkie”)<sup>11</sup>, or personal adverse experience (theft, violence, sexual assault, etc.). While some of these negative opinions of individuals are based on unfavorable personal experiences, many of them arise from ingroup/outgroup biases. Considering intersectionality of marginalized identities, ingroup bias can be filled with subtle nuances and complexity.

Mountain Man, who has been living outside for fifteen years, has been imprisoned, and has suffered a variety of structural mechanisms that have foreclosed many possibilities in his life. He has also lived through processes of exclusion in his daily life. However, he does not use substances other than marijuana and although he spends a considerable amount of time inside Change Point, he is often vocal about his disdain of “tweakers” and injection drug use in general. Ironically, Mountain Man is part of the “Satellite Exchange” program, which offers monetary incentives for individuals who return syringes en masse. This program exists to invoke a sense of stewardship for high use locations, encourage proper disposal and return of sharps, and boost return rates. Mountain Man goes around the camps and collects syringes that litter the ground for a

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<sup>11</sup> A “tweaker” is a person who uses methamphetamine and a “junkie” is a person who uses opiates in common slang.

small monetary rate of return. His contempt unravels during an interview question about community. He says, “Yeah, at least a better community<sup>12</sup> than I’m used to, ‘cause I deal with the clients. The idiots like Richie throw their needles. ((laughter)) He did give me thirty-three of them the other day. ((laughter)) But yeah, I deal with the clients.”

Mountain Man’s contempt of Richie was a theme throughout our conversations and throughout his narrative in the interview. Both men are white males, in the same age bracket, and both live outside. Mountain Man comes from a working-class family in the area and Richie is from an upper-middle class family in middle America. Richie uses methamphetamine intravenously as a self-reported form of self-medicating for severe PTSD. They have known each other for many years and have even camped near each other, however, preconceived notions based on substance use inform opinions about the other.

These biases from community members are often the same biases that shape the attitudes of care providers. Mountain Man says, “Some of the people, you’ll never be able to help them because they don’t respect themselves, they don’t respect anybody else. Until they get that, there’s no helping them. You can do what you can though to make their life a little bit easier, but many will jump off the cliff anyways.” Mountain Man’s statement is a testament to the underlying prevailing judgments about the complexities of addiction in America, and are often a consequence of compassion fatigue (also called secondary traumatic stress disorder or “burnout”) that affects many providers who work

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<sup>12</sup> Mountain Man is referring to the “community” outside of Change Point (ie. encampments, homeless shelter, etc.

with marginalized populations. According to Matt Bennett, a social services provider and trainer,

The most common impact of compassion fatigue is that, as our cup fills up with the negative life experiences of our clients, our worldview can start to become cynical. When this happens, things like homelessness, our political reality, racism, poverty, and other social problems can seem especially overwhelming. It might look like these issues may never end, and that we have little power to make any meaningful change. No matter how hard we work, tomorrow there will be homelessness, tomorrow there will be poverty, tomorrow a child will be abused, tomorrow a person of color will experience racism, and tomorrow a family will go to bed hungry (Bennett 2017).

While social service providers remind each other of “self-care” in an industry rife with compassion fatigue (Bride 2007, Stamm 1995), Mountain Man’s assertion unveils the complex layers of secondary trauma among people experiencing homelessness and how these traumas inform their opinions about others.

Non-users such as Mountain Man and Pamela complained often of the syringes that littered the places they frequented, yet both seemed to spend many hours each day at Change Point. Pamela<sup>13</sup> was previously a software engineer who lost her job during the recession, found herself “overqualified” for every job she applied for, and slowly lost all of her belongings and her home. Pamela was able to keep a few remnants of her past life: her pride, intelligence, kindness, and her two black German Shepherds. In the following paragraph, Pamela ruminates on her recent homelessness,

I have never been there before. I go from being, you know, not even a medium income person, but a higher...you know...to homeless. I mean, it’s a drastic change. And others, you know, can go and become not

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<sup>13</sup> “Pamela” (see acknowledgments) passed away during the course of this project of chronic health conditions.

homeless and become homeless again...and just roll with it. And, I don't think I could.

Pamela carries with her an updated resume and is still applying for jobs. She admitted that she had to alter her resume to avoid appearing too qualified for entry level positions. Pamela is still adjusting to life without a home and her response indicates a reluctance to experience homelessness again should she be housed. It also indicates her awe of the resiliency of individuals that experience years of homelessness, or episodic homelessness. Although she is recently homeless, does not use drugs, and came from an upper middle-class background, she is a regular at Change Point. Individuals like Pamela challenge the assumptions about what a "needle exchange" is and who accesses spaces like Change Point. Pamela did not come for the injection supplies, coffee, or pastries, rather she regularly came for social interaction and pleasantries of conversation, the hallmarks of a third space.

Attitudes and judgments, especially about entire groups of people mark ingroup and outgroup boundaries and reify processes of stigma and oppression. In this way, these prevailing cultural beliefs engender what Nancy Scheper-Hughes calls "everyday violence" in which inequality becomes so routinely administered that it becomes normalized and naturalized (1996). Additionally, individuals who receive a constant barrage of negative environmental influences (in addition to abject poverty, incarceration, discrimination etc.) are likely to incorporate these adverse ideals into their own identities, which in turn fortify barriers.

Structural violence, everyday violence, and symbolic violence may not be always be evident in the microinteractions of an ethnographic project, however, with an

adjustment to the focus and scope, these invisible forms of violence are apparent. The microaggressions<sup>14</sup> that pepper interlocutor's narratives about other consumers within Change Point and the margins, in general, subtly remind us of invisible and internalized hierarchies that become normalized within our cultural construction.

Through symbolic violence, inequalities are made to appear commonsensical, and they reproduce themselves preconsciously in the ontological categories shared within classes and within social groups in any given society. Symbolic violence is an especially useful concept for critiquing homelessness in the United States because most people consider drug use and poverty to be caused by personal character flaws or sinful behavior (Bourgois 2009b).

The reproduction of prevailing ideologies is constantly manifested through actions toward and vocalizations about other members of the consumer community at Change Point, despite the intentionality of the staff and volunteers. Although Change Point functions as a radically inclusive space, inclusivity remains contested by many who reify broader inequalities and structures.

### Conclusion

The diverse array of actors who help to create and maintain a social space of radical inclusivity are often challenged with the same tensions that exist beyond the confines of Change Point. Many of the consumers, volunteers, and staff members have a history of trauma and many have experiences that are shaped from multiple intersecting identities that have been historically disenfranchised. Despite the intentions of staff to create an open and inclusive community that works to reduce harm (individually and

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<sup>14</sup> A microaggression is "a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority)" (Merriam-Webster 2017).



collectively), structural violence often perpetuates through individual encounters, often in the form of microaggressions.

Despite internalization of marginality and stigma, Change Point remains a sanctuary of sociability that acts as a third space and a heterotopia for those on the margins of Reno. Situated within a high-density poverty neighborhood that is often described with pejoratives like “urban blight,” Change Point, despite its institutional designation as a syringe services program highlights differences between “place” and “space.” As many businesses within the area enforce systematic exclusion to people who use drugs, people experiencing homelessness, and sex workers, these individuals are able to help shape a radically inclusive oasis built on freedom of speech about a variety of topics considered taboo within other social situations, free will, mutual respect, and the reduction of harm.

The following chapter offers a brief evaluation of the ways in which harm reduction discourse becomes an operational strategy, both in the broad sense of public health and as an institutional that provides safe injection and safe sex supplies and HIV and HCV testing. It also identifies the ways in which consumers push back against institutional strategy to meet their individual needs by using what de Certeau calls tactics while identifying the tensions that arise from these divergent intentions.

## Chapter 4: Reducing Harm: Strategies and Tactics

“What is counted is *what* is used, not the *ways* of using.”  
(de Certeau 1984: 25)

The previous chapter discussed Change Point as an institutionally sanctioned place that provides sterile injection supplies and educational tools to people who inject drugs and a social space of otherness, which might be described as a third place or heterotopia. Further, it explored the practices that challenge the institutional formalities of place to create an inclusive social space. Within Change Point, encounters, demographic information, risk behaviors, tests (positives versus negatives), drug(s) of choice, syringes (returned and distributed), and items related to injection drug use are all quantified and reported to HOPES, the state, and other institutions. What is not quantified is how various actors understand and *practice* harm reduction. This chapter focuses on rhetorical strategies (using de Certeau’s meaning) as a conduit of institutional discourse and rhetorical tactics for meeting individuals’ immediate needs. Risk reduction and a specific set of practices relating to risk and risky behaviors create a shared linguistic repertoire and register to form a particular community of practice (Bucholtz 1999, Rampton 2006). Etienne and Beverly Wenger-Trayner define communities of practice as, “groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly” (2015). The staff and volunteers become well versed in what de Certeau has called “strategies” (de Certeau 1984) or ways in which institutional power enacts or enforces structural goals upon others. In the next section, I will focus on the ways in which consumers engage with harm reduction discourse while

using “tactics” (de Certeau 1984) to resist certain elements of discursive and organizational strategies while actively constructing a socially meaningful space.

During the research process of this project, what emerged as important were ways in which marginalized individuals band together to form a strong, supportive community in and around Change Point while drawing on elements of harm reduction. This chapter shifts that focus to the ways in which harm reduction provides a discursive framework on a broad institutional and public health level, and the ways in which various actors engage with this discourse but also understand and practice harm reduction differently. This chapter touches on the understanding of strategies versus tactics to highlight the tensions and conflicts that arise from an institutional objective to promote health and wellness and an individual’s prerogative to exert his or her own agency when making decisions about his or her health or daily practice(s) that influence health.

#### Institutional Strategy versus Consumer Tactic

De Certeau situates power within institutions and individuals, yet he delineates these varying forms of power through his understanding of the differences between strategies and tactics. A strategy is “the calculation (or manipulation) of power relationships that becomes possible as soon as a subject with will and power (a business, an army, a city, a scientific institution) can be isolated. It postulates a *place* that can be delimited as its *own* and serve as the base from which relations with an *exteriority* composed with targets or threats can be managed” (1984: 35-36). Further, tactical power is consumer power rather than institutional power, a tactic is defined as “a calculated action determined by the absence of a proper locus” (36-37). I understand this to mean

that tactics can be multidirectional and dynamic, rather than the unidirectional, static power of strategies. My aim here is not to portray Change Point as a nefarious institution that exists to distort power relationships, rather to tease apart the ways in which public health discourse concerned with risk reduction and pathogen transmission shapes this particular place and more pointedly, how consumers understand and practice harm reduction in a “tactical” form to meet their everyday needs (including social needs). As de Certeau says, “the space of a tactic is the space of the other” (37), which seems an apt way to describe a place that exists officially as an SSP while functioning unofficially as a drop-in center for the disenfranchised—individuals that are often “othered” by the media, law enforcement, and the general public.

The differences between strategy and tactic I understand best through visualizing a city as a metaphor. You need to get to an address that you are not familiar with, although you know this city well. You pull out your phone and open up a map application (or if you are more of a Luddite, I suppose you pull out your map). You notice that the streets are familiar, the streets would be aligned with an institutional *strategy* to get you from point A to point B with some level of organization and minimal unpredictability. You set off on foot and use alleys and paths through dirt lots. You opt for the shortcut. This is the pedestrian’s tactic—you reclaim your autonomy from city planners and engineers and get yourself from point A to B on your terms.

Robert Desjarlais applies the concept of strategic versus tactical forms of language and construction of agency in his ethnographic study of a shelter for the “homeless mentally ill.” In his article, he discusses the ways in which the shelter staff advance their “therapeutic agenda” as a “single, unified front” (1996: 883) by using

language that exhibited their “we-ness” (884). This collective voice of the staff underpinned the power differential and attempt to surveil and intervene behaviors seen as pathological or problematic. Conversely, the shelter residents spoke as individuals (not as a collective) and used the rhetoric of shelter staff to meet their needs. To residents, sociability became a commodity to advance their abilities to procure resources and to have their complaints heard. Dejarlais refers to the rhetoric of the residents as “registers of the real” (890). Similar tensions arose in the daily interactions observed at Change Point where the rhetoric of the staff, who were well versed in harm reduction discourse, contrasted with the rhetoric of volunteers and consumers.

#### Harm Reduction as a Framing Discourse

In the same study, Robert Dejarlais describes tactics amongst residents within a shelter for individuals living with mental illness. Shelter staff attempted to shape residents’ behavior through strategies of interaction that “promoted ideas of causality, regularity, reliability, and responsibility” (1996:884) while residents incorporated their institutional rhetoric “not because it made sense in the long run but in order to *get* things” (1196: 896 emphasis added). Although Change Point staff actively attempted to minimize the power differential between staff and clientele through peer support, rhetorical alignment, and non-judgment, clients were encouraged to return used syringes and were either verbally admonished for poor return rates or they were inconvenienced by completing a short quiz about disease, harm reduction, and barriers to returning syringes before they were allowed to access supplies. Return rates were extremely important due to the SSP’s obligation to report the number of syringes provided and returned and those

numbers drive budgetary funding as well as provide “evidence” to adversaries opposed to SSPs because there is more paraphernalia disposed of improperly in public spaces.

*“Meeting People Where They Are”*

A common theme that arises from harm reduction discourse distributed through websites, educational materials for practitioners, and conversations with service providers is “meeting people where they are.” What does this mean in this context? The hegemonic discourse amongst service providers in the alcohol and/or substance abuse is an abstinence based approach that coerces individuals to cease use entirely and attend twelve-step based meetings and treatment programs. This approach has been criticized by advocates of harm reduction as unrealistic while not acknowledging the complicated process of recovery that includes slips and relapses. During the course of my research, many PWIDs spoke of the shame and self-loathing that resulted from slips while engaged in abstinence only treatment. Harm reduction prides itself on pragmatically viewing addiction along a continuum ranging from excessive use to abstinence while focusing on the level of risk.

In the context of Change Point, risk assessment was a central theme in every aspect of services from the syringe services program (SSP) to testing. Volunteers and staff are trained to elicit information from clients through questions about practices, while offering education about safer injection practices, wound and abscess care, and sexual practices related to level of risk. Educational materials were provided that offered instruction in lay language about safe injection practices and overdose prevention. Sex

and drug use were discussed matter-of-factly without condescension or judgment—it was through these conversations that staff members and volunteers aligned themselves in “pragmatic solidarity” (Farmer 2005) with a vulnerable population. Staff members circulated idioms related to enjoying life while staying “safe” such as “I’m not tryin’ to yuck your yum” (Squirrel) or “I’m not telling you how to have your fun” (Chucky), and “one fix, one kit, don’t share shit,” which was said by multiple interlocutors.

The act of “meeting someone where they are” is about honoring another’s agency without being motivated to alter it with one’s own agenda. While this notion is prominent in the harm reduction arena, scholars have critiqued its neutrality (Nichter 2003, Shaw 2012). Susan Shaw notes that the consumers in her research at an SSP portray themselves as ethical subjects to outreach workers to mitigate negative responses about risk while engaging in risky behaviors. Shaw also critiques community health organizations/workers and harm reduction as agents of governmentality and public health surveillance (2012).

Harm reduction discourse reflects what Robert Desjarlais calls a “therapeutic agenda” (1996) which draws “from core themes in white, middle-class American culture and the culture of therapy in particular” (1996:883) and has broadly been criticized for simplifying PWIDs as rational actors who base decision making about risky behaviors according to rational choice theory. “Meeting someone where they are” is conceptually similar to what Michel Foucault discusses as “incitement to discourse<sup>15</sup>” (Foucault 1990, Wilce 2009) in which interlocutors are expected to confess openly the truths of their personal practices to a volunteer or staff member who conducts a “risk assessment” to

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<sup>15</sup> From *The History of Sexuality*. Foucault used “incitement to discourse” to discuss how the pleasure of sex was disclosed (in Western society) only by means of confession, which informed psychoanalysis and the ways in which pleasure and desire are understood.

help the client make safer choices. These interactions based on risk assessment and risk reduction honor agency while simultaneously attempting to manipulate agency.

*“The Whole Hand”—Creating Community*

A staff member, Angus, describes Change Point as a “whole hand,”

Angus: And you know, that’s what I love about Change Point services, we’re here to offer you the whole hand—not a finger. We’re not here to wag the finger at you and tell you to stop or change. We leave that up to you, you know, as the client to make those changes, and *you* to decide what changes are appropriate for *you* as a client.

Angus’s statement reflects the prominent ideology of “meeting people where they are” embedded within harm reduction discursive arenas and common among outreach workers, community health workers, and other service providers. His use of descriptors such as a whole hand connotes openness and aid, whereas a finger implies shame and coercive pressure. While harm reduction discourse avoids shaming and promotes individual empowerment, there is still an understanding of the risk continuum that is based on biomedical discourse which marks some behaviors as “safe” or good, or as “risky” and destructive towards one’s health. In this way, the staff of Change Point is much like the staff of the homeless shelter for the mentally ill Dejarlais describes that temporally locate risk and promote “ideas of causality, regularity, reliability, and responsibility” (1996:884). The concept of the offering hand extending to a PWID is open and nonjudgmental, but it is also filled with institutional or state sanctioned options based on a particular discourse related to risk, health, and recovery.



*Volunteers and the Rhetoric of Risk*

As mentioned in the previous chapter, the volunteers who donate their time to working within the walls of Change Point are motivated by a variety of divergent experiences. Roxy, Pua, Chucky, Juan Jose, and Magone are motivated by lived experience, Alice was motivated by addiction touching her own family, and Delirium and Waves were initially motivated by academic factors. As a result, the rhetoric employed by volunteers ranged from a focus on risk reduction (largely as a result of living with HIV), social justice, or ending drug use.

Public health strategies are explicit in many of the interviews with volunteers as well as in their observed interactions with consumers. “Chucky,” notes the following about harm reduction,

You’re gonna come in here and get condoms or needles, okay. That’s not saying that we’re gonna say, ‘oh you have to stop drinking. You have to stop having sex for money. You have to stop doing whatever you’re doing. It’s okay. How can we get you to do whatever you’re doing in your life, but it’s the safest way possible? So if you are having sex for money, how do you do it safely? Do you use condoms? Do you use dental dams, you know? Do you practice oral sex versus penetrative sex? If you’re a junkie, how do we get you to shoot up safely? We give you all the supplies to do it. If you’re a business man and you just you know...a recreational user, and you only use like once a month...how do we keep you safe on those days? You know, we make sure you have *access* to whatever it is you’re using.’ And we educate. Mostly harm reduction is a lot of educating.

Chucky’s understanding and application of harm reduction discourse outlines the ways in which rhetoric becomes a strategy to curtail behaviors seen as problematic and impact a

consumer's agency to alter their practices in their lives for a specific end—to reduce risk. In addition to the constant education provided to consumers during daily interactions, educational materials on disease, recovery, intimate partner violence, safe injection practices, and drugs were found in multiple locations and educational posters peppered the walls in each room. The physical place cast the strategy of harm reduction from all angles, but were consumers practicing risk reduction in their daily lives?

### Practicing Harm Reduction or Doing it to Others?

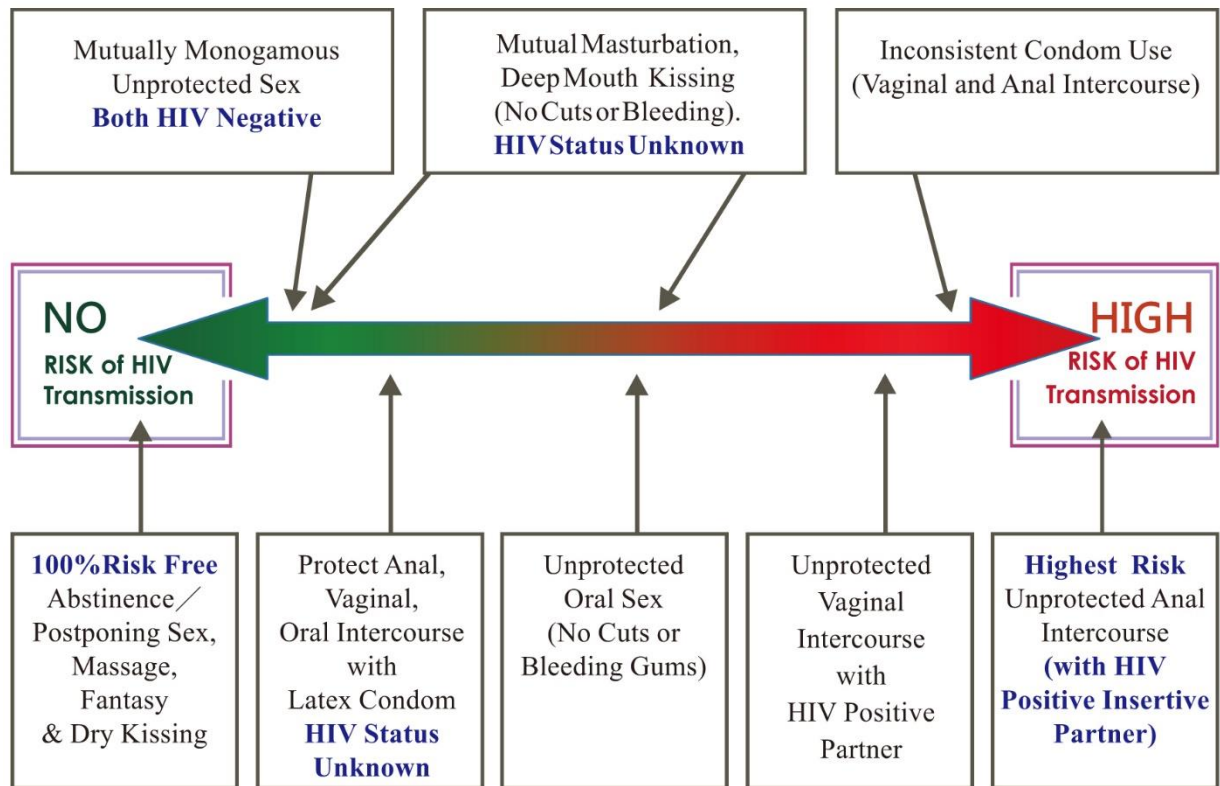
In many interactions with consumers, I noticed that they were often concerned with distributing sterile injection supplies within their own social networks but often admitted that they used after friends, reused injection equipment multiple times, used dirty water to mix their shots, or did not use some of the supplies themselves. Many of these individuals would admit to providing education about sterility and risk to others in their cohort—a compelling discontinuity. Many interlocutors, including those who did not engage in substance use, passed out sterile injection supplies and educated their peers about safe injection practices. Consumer agents internalize discourse but actively negotiate and resist harm reduction in their personal lives by “doing” harm reductions to others through discursive practices while minimally using harm reduction strategies within their daily lived realities. These incongruities between beliefs and actions points to a sort of cognitive dissonance that consumers displayed.

*“I’m Pretty Reckless”*

Conversations about a variety of ways to reduce risk took place all day during my time volunteering at Change Point. Often, I worked “SSP” in which I was responsible for collecting data, dispensing sterile injection supplies, wound care supplies, hygiene items, collecting “dirties” (used syringes), and providing consumer education about a wide variety of topics that included: alternating injection sites, hydration, current batches of “bad” drugs locally, overdosing, overamping<sup>16</sup>, and checking “misses” and abscesses. I was also trained and licensed to perform HIV and HCV rapid tests and counseling. During these tests, I was responsible for data collection and input, ensuring signed consent forms, performing and reading the test, and counseling on risk reduction while offering helpful suggestions about not sharing injection equipment (including cottons and cookers), safe sex, and PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) to prevent HIV transmission. In these interactions, I also incorporated various idioms related to harm reduction that I learned from others in this space, including “I’m not trying to yuck your yum,” and “I’m going to poke your finger, run the test and we’re going to talk about weed, speed, rock’n’roll and birth control,” and “let’s take a look at this wheel of fun, which is also associated with risk. Lots of fun—lots of risk. Then we’ll talk about the best ways we can keep you safe while having the kind of fun you like” (See Figure 4.1).

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<sup>16</sup> “Overamping” is overdosing on stimulants (cocaine, methamphetamine, etc.)



**Figure 4.1 (“Level of Safe Sex” 2015)**

Conversations about risk reduction place an emphasis on individual agency and individual power to modify behavior seen as problematic or risky, however, the central objective is to manipulate this agentic power by placing value judgments on choices along a continuum. In any case, it tends to be much more effective than a heavy handed prohibitive approach which does little to dissuade individuals from engaging in an activity, rather it empowers individuals to consider safety while engaging in those activities.

During many conversations about condom use, for example, consumers would readily share their understanding of how use of condoms was essential to preventing STI's. However, when asked if they always use condoms, consumers readily admitted

that in the heat of the moment condoms were often forgotten. Similarly, when discussing sharing injection equipment IDU's often proudly declared that they never shared, however, when asked if they shared cottons, cookers, or "piggy backed"<sup>17</sup> the answers were commonly "yes." Consumers regularly contradicted themselves during conversations by reporting their frequent visits to the SSP and then reporting that they often re-use a syringe until it becomes quite difficult to use. In one interview, "Youngster" describes his behavior:

Um, honestly, I hate to say it like this but I'm kinda reckless when I use points. I mean, I don't, I shake'n'bake it. I put it in the rig and I pull back water and I shake it up until it dissolves. You know what I mean. I don't use alcohol wipes. I'm not sanitary at all, I'm pretty reckless, and I think that's why my tracks are so bad.

Youngster fails to project himself as an "ethical self," rather, he acknowledges that in his own practices he does not follow the discursive strategies that volunteers and staff members promote through education about safe injection, nor does he use the supplies as instructed by Change Point workers and literature. Many interlocutors who utilize SSP services acknowledged their own poor health conditions (congestive heart failure, hepatitis, endocarditis, HIV and others) that act to promote themselves as living testimony to others as they "do" harm reduction to others.

Youngster admits that he is not using the cookers or cottons provided by the SSP, rather he engages in a practice that offers a shortcut to meeting his immediate desire to inject methamphetamine. By opting for a "shake and bake"<sup>18</sup> method, rather than filtering

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<sup>17</sup> "Piggy backing" or "backloading" is a method of drawing up drugs in one syringe and sharing with others by injecting them into the back of another/other syringe(s).

<sup>18</sup> The "shake and bake" method that Youngster referred to means to mix one's drugs with water in the syringe rather than to use a cooker and filter out particulates with a cotton or other type of filter.

the drugs mixed with water through a cotton, he risks adding pollutants directly into his bloodstream. By choosing not to sterilize the injection site or alternate injection sites, he is developing scar tissue in the form of “tracks.” Right after the above was said, I followed up with a query about Youngster telling me that he distributes injection supplies to friends. He replied with,

There’s a lot of people who don’t come down here. And so, you know what I mean, I’ll hand ‘em like, when I see ‘em I’ll hand ‘em like five and I know that guy’s like handing his friend like two. You know what I mean. He’s taking three for himself and now his friend has two. I’ll take like thirty with me, and I’ll use maybe ten of them. Most of ‘em get handed out to friends. I’m not tryin’ to trade ‘em or sell ‘em. I give it to a friend and I bet if I give a friend ten, he’s gonna give someone else like four, five, six.

The above is illustrative of “doing” harm reduction as a practice one “does” to others rather than practice themselves. Youngster admits that he is “reckless” and chooses not to use sterile supplies or alternate injection sites. Youngster also regularly tests for HIV and HCV, which points to his risky behavior and his adherence to an accepted strategy to reduce harm. He regularly distributes supplies to his friends in an effort to share knowledge and material items from the SSP. His narrative illustrates the tactical nature of navigating this space as a consumer. He is aware of the ideology of harm reduction, regularly passes out supplies, but does not practice these behaviors despite this knowledge. He states,

Harm reduction is uh, there’s gonna be harm. You need to use drugs. It’s gonna affect our bodies in a negative way, but harm reduction we’re using, um, sanitation, um sterile utensils to use our drugs, I guess. Use our drugs. Yeah, um, so we’re just um trying to make some responsible choices if we’re not making, you know what I mean. If we’re not doing exactly what we want to do. We’re at least trying in certain areas.

...Well because if you have harm reduction, you know what I mean. If they decide to get sober in the future, their body is not all fucked off. You

know what I mean? There's not like hella crazy shit that's wrong with 'em. So they're fine, you know what I mean? It makes 'em better if they decide to get sober and people decide to get sober all the time.

In this passage, Youngster invokes temporality into his rhetorical stance on harm reduction, contemplating a future self that is healthy despite his present drug use.

Youngster also uses “you know what I mean” both as a statement and a question, imploring his audience to align with him in his positioning. While Youngster seems to ideologically understand harm reduction and locate its validity across time and space.

Most of the interlocutors I encountered at least had a rudimentary understanding of harm reduction and many were well-versed on the topic. Whether or not they practiced harm reduction in their own lives illustrates the divide between theory and practice, strategy and tactic.

The knowledge production within Change Point derives from broader public health objectives with a strategic intent to reduce pathological impact to both individuals and communities. The biomedical discursive arena is primarily concerned with prevention, diagnosis, and treatment (the former is largely informed by public health knowledge production). Each actor within this space becomes both knowledge consumer (staff and volunteers receive constant training) and knowledge producer. In this way, institutional discourse is transmitted between broader public health institutions and policies (“best-practices,” “evidence-based,” “clinically reviewed” et al.), service provider, and consumer. Inversely, it is the practices of consumers (new drugs, new modes/patterns of consumption, injection practices, subsistence strategies, etc.) that shape broader policies through the knowledge/data collected by service providers. SSP's collect data on drug use, mode of use, demographic information, collection rates and attempt to

persuade PWIDs to inject their drugs a certain way (ie. using sterile water or saline, a new syringe each time, a filter, get regular HIV and/or HCV tests, and return used syringes). These strategies are both “a form of manipulation” (Nichter 2003:13) and a form of health “surveillance” and “governmentality” (Shaw 2012).

### *Meeting Needs—Consumer Tactics*

Reflecting back to the beginning of this thesis, inequality was discussed in terms of community and individual scarcity. Consumers who interact with Change Point often feel the pangs of resource scarcity, invisibility, and expulsion. They are often defined by that which they lack: sobriety, a home, identifying documents, children, family, food, health, etc. The vicinity is also defined by absence. Thousands of families, seniors, and disabled individuals (many living on a fixed income of approximately \$733.00 per month) live in neglected and run down motels. The Fourth Street Corridor is also a food desert, with many individuals only able to shop for food at convenience stores or eat the free food available through various pantries. As a result of absence, lack, and need, my field journal is full of notes about daily conflicts—usually over resources. As much as there was a “moral economy of sharing” (Bourgois 2009b), there was a hefty amount of theft within the houseless community. One day a week, a local natural foods store brought their weekly donations and volunteers hurried to the lobby carrying the large yellow plastic crates, each crate filled with items like produce, fruit, ready-made sandwiches or salads, or the occasional dessert or frozen meat. It was on this day each week that so many tensions and conflicts arose between community members.



Richie had a lot to say about the people who only came for the food but did not engage with the space on a daily basis. He says,

you know, you get a lot of crap coming in here just for food. And then you know the people who are actually sitting in here waiting for services, they don't get to benefit from anything...and then you get these people (.03) and like me, I hang out here all the time but I don't hang out here for the food. But I mean there's people who just come here and they'll hang out here all day long, or until the coffee runs out and they're gone...I mean, it's stupid. That's why I say it's either one way or another, you know. But I mean, I think it's great. And I wouldn't want to stop people but it brings in a lot of people who are...may not be here. You know, and they don't give a shit what happens here. They really don't.

Me: So they're not part of that 'community'?

Richie: No. They're just here to get a free lick and move on. They've never exchanged a needle in their life. You know, and they never will. Be they go out there and drink until they're intoxicated so bad that they puke and piss themselves and come in here and try to get some coffee in the morning—and then sit here all day until it's gone.

In the narrative above, Richie also complains about non-drug users who often hang out each day at Change Point. Richie's rhetoric sheds light not only on insider versus outsider status, but how other individuals access the space not for injections supplies or testing, but for socializing over coffee. This third space is fueled with tension between the tactics of the consumer to meet their individual needs and institutional strategy to reduce risk.

Not all of the interlocutors "did" harm reduction to others but failed to practice it themselves. A few were adamant that they used the sterile injection supplies for each use. Upon reviewing the transcriptions multiple times, the two individuals that were concerned with sterility and single use were living with chronic illness. Gypsy spoke about packing up his camp and he found a stash of needles that he was unsure whether they were new or used. He was concerned that he may transmit a virus to his girlfriend

and disposed of them in a sharps container. “I’d rather be safe than sorry, especially with my new girl now, she doesn’t have the hep C or the HIV and I mean, I wouldn’t want her getting a hold of one of ‘em. And I told her that flat out... I’d rather be safe. I don’t want to be the one responsible for her gettin’ what I got...over stupidity.” There are other health concerns to be wary of as well and require diligence when injecting drugs.

Trainwreck lives in pain and hypervigilance about his health due to polymorbid illness, he reflects, “Sterility. I mean I’m into major sterility. I’m very vulnerable to endocarditis, you know and I’ve definitely damaged my health quite severely from my substance abuse. And a lot of that’s not just because of adulteration in substances and a lack of pharmaceutical quality. A lot of that is just because of what I was doing. You know?” In these two cases, the interlocutors’ autonomy and agency align with the public health stance on risk reduction and health while still meeting their individual needs.

### *The Tactical Tension*

The uniqueness of Change Point is underpinned by the diversity of the actors who create and maintain it as a third space. It is not uncommon for consumers who regularly exchange to be given hundreds of needles and return a few, if any. Conversely, many people who return large sharps containers with used syringes for disposal are not IDUs. Change Point began a “Satellite Exchange Program” to incentivize large returns by offering a monetary reward<sup>19</sup>. There are several individuals who return hundreds or

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<sup>19</sup> During the time of fieldwork for this project, the monetary reward was \$5.00 for each 500 syringes returned.

thousands at a time and are provided hundreds of new syringes to distribute amongst their social network(s). Many of these “Satellite Exchangers” live in the rural areas and provide a much-needed service to people who may have transportation barriers to access Change Point themselves. Some exchangers, however, live in encampments that are littered with used syringes and they walk the river paths and empty lots searching for discarded syringes to place into their sharps containers. Non-drug users who become satellite exchangers to diversify their subsistence strategies add a tactical irony to Change Point as an SSP.

Some non-drug users like Pamela adopt the public health rhetoric and ideology into their narratives about syringes and harm reduction. Pamela says,

We’re trying not to...I would say we’re trying to reduce harm for the outside community or those individuals using that type of ‘object’...you know, needle or other...from you know, catching bad diseases. Or you know actually discarding them where others might find ‘em and actually do harm to them or others, you know. Or people accidentally falling over them, falling on things, you know. Just, if you’re gonna do this, do it responsibly, you know.

Pamela coopts the institutional discourse relating to transmission of blood borne viruses through sharing syringes or accidental needle sticks and incorporates it into her own embodied experience (*habitus*). Although many consumers within this space have adopted rhetorical elements of public health strategies to mitigate risk, most consumers are either experiencing homelessness, using and/or injecting drugs, engaging in sex work, living in poverty, or navigating the world as Latino/a, African-American, indigenous, or LGBT and consequently take a tactical stance to maneuver through the challenges that the day (or next moment) may bring. Despite the efforts of public health, HOPES, or Change Point to manipulate agency towards individual and collective health, consumers

must meet their individualized needs as *they* see them, rather than what others (despite best intentions) may identify as needs.

The coopting of discourse and shifting from tactics to strategy to tactics seems fitting in the particularities of this social context and parallels the history of harm reduction and syringe access in the United States. Reflecting back on the history of harm reduction, it was through tactical actions of PWIDs turned activists (like Jon Parker) that shifted public health discourse towards the harm reduction model. In this way, “a tactic is the art of the weak” (de Certeau 1984:37), which in the case of harm reduction has become a public health strategy that often assumes a rational actor approach. Philippe Bourgois challenged public health outreach by calling out ways in which a middle-class discourse inadvertently enacts symbolic violence. Bourgois states, “knowledge may be empowering to the middle class, but prevention and outreach messages that target the decision-making processes of drug users fail to address the constraints on choice that shape need, desire, and personal priorities among the indigent” (2009b: 106). The power differential between service provider (whether volunteer or CHW) and consumer exists despite best efforts to diminish it.

### Conclusion

Within interstitial spaces there is a tension, but there is also a possibility for creating an inclusive community. The practices of individuals inform healthcare policies just as policies impact individual practices, it is a generative process. De Certeau states that tactical mobility “must vigilantly make use of the cracks that particular conjunctions

open in the surveillance of the proprietary powers. It poaches them. It creates surprises in them. It can be where it is least expected. It is a guileful ruse” (1984: 37). Individuals who comprise this community are more than a “community of addicted bodies” (Bourgois 2009b) and Change Point staff does not rank them in terms of “morally legitimate suffering bodies” (Ticktin 2011:11) nor project pathology with a “medical gaze” (Foucault 1973). Harm reduction exerts biopolitical pressure by constructing some corporeal practices as favorable (less risky) and some as unfavorable (risky). The institutional strategy sets its aim on reducing disease and public health impact. However, the consumers at Change Point, through complex and diverse tactics must focus on meeting their individual needs due to structural barriers and the difficult conditions of their lives.

Language has the enormous capacity to shape the ways we live our lives, how we think, how we are disciplined or rewarded, how we feel, and it impacts structural forces and institutional practices. Words do things in the world and institutional discourse shapes the world we live in. Alessandro Duranti emphasizes that not only do linguistic expressions shape the world, but they also impact social identities (1997). With this consideration in mind, institutional discourse most often perpetuates symbolic violence across axes of societal power that become internalized by individual actors. Harm reduction discourse seeks to empower the disenfranchised through a public health discourse that is often enacted by individual actors through microinteractions.

Ben Rampton states that the concept of community “can’t only be seen as co-participation in locally embedded practice” (2006:5), rather, “‘community’ serves as a symbol and sign itself” (2006:6). What does this mean for communities that arise from

institutional discourse yet exist on the margins? Can these spaces of otherness be colorful communities burgeoning with the possibility of socially meaningful heterotopias shaped by harm reduction discourse and lived experience? What kind of symbolic meaning becomes embedded in a community of this kind?

Edward Soja says, “Taking the socio-spatial dialectic seriously means that we recognize that the geographies in which we live can have negative as well as positive consequences on practically everything we do. Foucault captured this by showing how the intersection of space, knowledge, and power can be both oppressive and enabling” (Soja 2009:2). If harm reduction supports the ideology of empowering individuals towards incrementally taking steps to reduce harm, this could include social as well as corporeal forms of harm (suffering). Certainly, harm reduction can be used as a strategy of institutional power to manipulate the actions of PWIDs as Nichter (2003) and Shaw (2012) suggest. However, it can also work as a tactic in which actors assert their autonomy in making their own decisions while creating a colorful social space in which heterogeneity generates inclusivity and a third space for sociality.

#### Vignette IV: High Stakes

*I briefly worked SSP today, and patrons eagerly told me their stories, each lasting around twenty minutes before I actually got to ask the questions on the customary SSP form. Hopefully, one of the individuals with whom I conducted an exchange will meet me tomorrow morning for an interview. The young man is still a teen<sup>20</sup> and discussed his experiences with using in explicit detail. Both of his parents used heroin and he experiences deep self-esteem issues including negative self-talk which tells him he is worthless. He states that when he uses crystal, he feels “normal” and the negative mind chatter quiets itself.*

*I also chatted with an SSP patron who confused me. Her lengthy story reflected the productivity of human language as she added words in a long, stream-of-consciousness string of word gumbo in which the individual words were intelligible, however, together it was nonsensical. At one point, she told me that she was bitten by a plant and it injected venom into her. She said that she is allergic to the outside and that she has no brainstem and her brain is disintegrating so her right foot is her brain. She said that people can live without a head and neck and when her driver license expires in 2020, she will no longer have a head and neck. This conversation, as baffling as it was, is a good reminder of potential ethical dilemmas that could arise during recruitment for this project.*

*A pertinent afterthought after reflecting on my day is about a conversation that I had with a regular patron of CP. This individual told me the story of finding a body under the bridge recently. The man was laying awkwardly on the concrete incline of the underpass, motionless. The man and his girlfriend assumed that he was sleeping, however, in the morning they discovered that he was deceased and had been for several days. The man, he said, had maggots coming out of his mouth and eyes and was quite bloated. They reported this to a pastor at a nearby church who called the police. The police drove the couple to find the body and quickly disposed of the man (who had a spoon and needle) without crime scene tape etc. The reason this is so relevant is that people assumed to be addicts, who have accidentally caused their own demise are closed cases, quickly solved and disposed of. Dead addicts are disposable, however, they are someone’s loved one, lover, child, friend, sibling, parent, etc.*

--Fieldnotes July 9, 2015

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<sup>20</sup> He is still a teen but not a minor. All interlocutors are at the age of legal majority (18).

## Chapter 5: Conclusion

“I think this is a community all on its own right here. I really do. This whole entire...the entire thing here...the hospital, everything. It’s one big community. It really is. It truly is. I mean when you come in here, you’ve left Reno. You’re in a different place. You really are.” (Richie, Interview 2015)

The significance of Change Point as a social space is created with intention, formulated from the hybridization of medical, public health, harm reduction, and street discursive arenas. Multi-scalar layers of local institutional discourse filter from global macrodiscourses on risk reduction and health through agencies such as the World Health Organization, to the national Centers for Disease Control and Prevention, to the Nevada Division of Public and Behavioral Health, to the Washoe County Health District, Northern Nevada HOPES, and Change Point. In fact, during my research, the Change Point staff’s job descriptions changed from Harm Reduction and Outreach Workers to Community Health Workers, indicating this shift towards “health” rather than “outreach.” This shift seems to indicate an alliance with the institutions previously named. Although Change Point has a unique connection to its larger FQHC benefactor, it functions as a unique heterotopic third space, a space of “otherness.”

Institutionally sanctioned forms of communication or strategies, frames communication within Change Point about health, wellbeing, and risk reduction, even within everyday conversations among consumers. Communicative acts against sanctioned framework, or tactics, also act to position actors as co-creators of this specific third space. It would be an easy transition for Change Point to transform into a clinical space, perhaps if the actors actively shaping the internal discourse were clinicians rather



than peer Community Health Workers. However, if clinicians were shaping the discourse, there would likely be much more tension and distance between staff, volunteers, and clients. Instead, Change Point operates as a third place in a Foucault, de Certeau, Soja, and Oldenburg sense—creating a burgeoning space of possibility that is not clinical and not “everyday” life.

Ray Oldenburg (1989) posits a “Third Place” as a space of sociability based on Georg Simmel’s concept of “pure sociability.” In his book *The Great Good Place*, Oldenburg describes characteristics of third places including neutrality, conversation, accessibility, and inclusivity. He states, “The preferred and ubiquitous mode of urban development is hostile to both walking and talking. In walking, people become part of their terrain; they meet others; they become custodians of their neighborhoods. In talking, people get to know one another; they find and create their common interests and realize the collective abilities essential to community and democracy” (1989: xiv). Although Change Point has a particular functionality as an SSP, the lobby and outside porch become a space of social exchanges in which individuals connect with one another while sipping the free coffee from the lobby.

Oldenburg is skeptical about the prominence (or even existence) of third places within urban built environments, however, to populations largely excluded from urban private and public places, a location that allows for the freedom of sociability is an oasis to those excluded elsewhere. I tend to view urban landscapes as the ideal setting for third spaces for the marginalized to build relationships and community. Homi Bhabha’s work on cultural hybridity and its relation to creation of third spaces that disrupt hegemonic constructions of identity seems a more apt understanding of urban third spaces. Further,

Edward Soja's understanding of "thirdspace" provides context to the term. Soja describes the actual buildings as firstspace, secondspace is how the area is perceived, and thirdspace is the lived space (1996). My work builds upon Lefebvre, de Certeau, Foucault, and Soja, all of whom understood how spaces of "otherness" contest and resist social spaces within modern urbanity. Additionally, this work builds upon Butler's understanding of relationality and the ways in which we spaces are re(made) by the individuals within them.

Life at the margins emanates from a locus of social injustice and unequal distribution of material and social resources. Social geographer Edward Soja focuses on spatial (in)justice that carves out social spaces distinctly entwined with broader structural systems of power and result in marginality. The results of spatial injustice are communities that are compartmentalized according to race, class, ethnicity, language, religion etc. In other words, social distinctions become materialized into spatial distinctions (see Lefebvre, 1974, de Certeau 1984, Wacquant 2008, Soja 2010) in a socio-spatial dialectic.

Many individuals who access Change Point on a daily basis have been socially excluded as pariahs across various axes of inequality. Consider Pamela, who despite being a paying customer at a fast food restaurant, was expelled due to her housing status. Recall the stories of individuals who were treated poorly at hospitals due to their drug use. Furthermore, PWID's and those experiencing homelessness have been spatially excluded—cast out of public spaces and private establishments and objectified through media outlets as a homogenous entity that is best hidden from the sanctity of public streets. There is not only an embodied consequence of exclusion but a social consequence

as well—loneliness and isolation. Mother Theresa said, “The most terrible poverty is loneliness, and the feeling of being unloved” but loneliness and social isolation also affects health and premature mortality. According to the American Psychological Association (2017), “loneliness and social isolation may represent a greater public health hazard than obesity” as data confirms a connection between social isolation and chronic illness. People living with a stigmatizing condition such as mental illness, homelessness, addiction, HIV, or hepatitis C experience social isolation as a result of social exclusion. Change Point staff, volunteers, and clients welcome the unwelcomed form a thriving community which in itself helps to create possibilities for better health for the vulnerable. Creating radically inclusive social spaces reduces harm through building social relationships.

#### Late to the Game—the Benefit of “Best Practices”

During the course of this project the administration of the United States has changed from one focused on healthcare for all Americans, Medicaid expansion, mental health services, housing, and addiction treatment under Barack Obama. As I finish this thesis, we stand to lose all of that under Donald Trump’s administration. Projects that focus on our most vulnerable citizens are needed to substantiate how essential these services are and how meaningful they are. As Trainwreck says, “harm reduction is people taking care of themselves or having access to being able to take care of themselves, or learning how to take care of themselves. Basically, helping people stick around, you know? ‘Cause you know, even junkies have somebody that loves them somewhere, you know.” America is at the brink of losing healthcare, housing, and essential services while

facing an epidemic opioid crisis<sup>21</sup>. Cities are being gentrified and pushing communities of color and people living in poverty out of their homes. Service providers and clinicians are scratching their heads wondering how to help the teeming masses with chronic health issues, food insecurity, mental illness, addiction, and are unstably housed (if housed at all). Incarceration rates in this country are higher than any nation in the world. With all of these structural issues, it is important to create radically inclusive and socially meaningful spaces for those on the margins.

*The Body, Inequality, and Health*

The stakes of exclusion extend beyond social denial of one's humanity, rather the consequences of enforcement breach boundaries of negative social sanctioning into the biopolitical (Foucault 1984a:266) mechanisms of the "juridico-discursive" (Foucault 1978:82) arena and even humanitarian organizations vis-à-vis the "medical gaze" (Foucault 1973). Western society has attempted to regulate actions perceived to be immoral and self-destructive to the body by legal sanctions that seek to legislate "correct" and "incorrect" corporeal practices. In this way, institutions and more broadly the juridical system, have acted as apparatuses to enforce normative corporeal standards. These "normalizing" forces transform bodies into objects that can be controlled and manipulated by institutions in a series of deleterious formations of what Paul Farmer calls structural violence (Farmer 2005). Foucault explores how bodies become sites of political and economic power by stating, "the body becomes a useful force only if it is both a

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<sup>21</sup> According to the Centers for Disease Control and Prevention, 91 Americans die every day from opioid overdose (CDC 2017)

productive body and a subjugated body” (Foucault 1984b:173). Unfortunately, under the War on Drugs, many bodies become subjugated through institutionalized discipline that forecloses the possibility to be seen as productive. The criminal justice system has relegated millions of individuals in the U.S. “to the margins of mainstream society and denied access to the mainstream economy” (Alexander 2011:4).

The United States has a long prohibitive history, which is beyond the scope of this thesis, however, the current model of drug prohibition began in 1970 when the U.S. Congress passed the Comprehensive Drug Abuse Prevention and Control Act (now called the Controlled Substances Act), which hierarchically scheduled psychoactive substances into five strata according to their abuse potential and accepted medical use (Fisher and Harrison 2013). The phrase “War on Drugs” was coined by President Richard Nixon shortly after the Act, during a speech in 1971 (Fisher 2006). This “war” has become a lucrative endeavor, and most of the funding is spent on interdiction, militarized law enforcement, and incarceration (rather than treatment and prevention). It is undoubtedly the drug war that has created the highest incarceration rate in the world for the United States.

The drug war in the United States has become an apparatus of social control that has been used to segregate and exclude millions of Americans from participation in social life due to drug related charges. Michelle Alexander states, “Criminals, it turns out, are the one social group in America we have permission to hate” (2011:141) which creates negative consequences that extend beyond the reaches of any razor wire fence around a prison. Individuals may be able to manage a social identity (Goffman 1963) after a period of incarceration, however, one’s personal identity (Goffman 1963) is marred by recorded

convictions, the consequences of which seep into the rest of one's life chances—which have intergenerational implications.

Individuals convicted of drug related felonies remain excluded and locked out of many areas of civic participation after serving their sentences. Ex-felons are permanently excluded from the right to vote (in many states), receiving public assistance, federal student financial aid, and all too often, they are denied the right to participate in legal employment—a result from employers who would prefer not to hire those with a blemished personal identity (Alexander 2011). In this way, the “juridico-discursive” (Foucault 1978:82) arena is a formal apparatus of biopolitical control over addicted bodies that extends beyond the “carceral apparatus” (Wacquant 2000).

Unfortunately, the consequences of failure to perform according to societal standards are real. Stigmatized individuals face individual suffering and discrimination, and stigmatized groups face structural inequality and symbolic violence that legitimizes inequality and exclusion from engaging in many facets of social life. Negative social sanctions take their toll on stigmatized individuals, and often the consequences move beyond the social realm into codified legal sanctions against perceived social deviance. These consequences often perpetuate layered alienation to individuals perceived to be members of certain populations, for example many cities find ways to incarcerate unhoused individuals for minor infractions for which other citizens would not be penalized. In my work with addicts, appearance and mannerisms play a predominant role in visibility of stigma to others. All too often individuals who appear emaciated, nervous, or “shady” by societal standards are often marked by authorities as “suspicious” and are frequently incarcerated. Race, ethnicity, socioeconomic class, tattoos, and other visibly

stigmatizing attributes mark bodies as targets for police stops and arrests. Police profiling extends to assumptions about criminality based on appearance, which is many times tied to depictions of “criminals” in the media. “As long as you ‘look like’ or ‘seem like’ a criminal, you are treated with the same suspicion and contempt, not just by police, security guards, or hall monitors at your school, but also the woman who crosses the street to avoid you” (Alexander 2011:162).

Embodiment of social inequality has tangible, physiological consequences that cannot be extricated from the social consequences of segregation, alienation, and incarceration. According to the World Health Organization, social determinants of health “are shaped by the distribution of money, power and resources at global, national and local levels” (WHO 2015). The Centers for Disease Control and Prevention acknowledge five social determinants of health that include genetic and behavioral factors, social and physical environment, and access to health services (CDC 2014). Poverty and housing become central determinants in not only the quality of life, but the duration of life.

Many theorists have offered their theoretical and methodological approaches to understanding and working to eliminate health disparities in marginalized populations. Medical anthropologist Merrill Singer proposes the unique and specific term “syndemic” (Singer 2009) to describe the dynamic relationship between epidemic disease(s) and socioenvironmental contexts. Further, Singer adds the term SAVA, an acronym describing “the complex interactions that occur among substance abuse, violence, and AIDS” (Singer 2009:31). SAVA syndemic is useful to describe the complexities of interrelations between physical and sexual abuse, child neglect, intimate partner violence,

everyday violence (Scheper-Hughes 1996; Bourgois 2009a; Bourgois and Schonberg 2009b; Singer 2009), symbolic violence (Bourdieu 1977, 1999, 2000; Bourgois and Schonberg 2009b), structural violence (Farmer 2004, 2005; Bourgois 2009a, 2009b), substance use, and HIV and hepatitis C infection. Drug use often accompanies social exclusion through various mechanisms that attempt to coercively correct behavior that is often perceived as moral failure or a lack of will (Goffman 1963). The stigma of substance use relegates people who use drugs to the social margins spatially through lower socioeconomic neighborhoods, jails, prisons, institutions, and early death. Stigma also acts as a preventative mechanism to accessing mental health services, employment, healthcare, housing, and treatment. The current moralized ideology of the abstinence model further isolates and shames drug users without adequately addressing the links between trauma, violence, and abuse on drug use (Bourgois 2003; Hofrichter 2003; Maté 2008; Bourgois 2009; Bourgois and Schonberg 2009b; Singer 2009; Bourgois 2010).

Medical anthropologist Paul Farmer also offers his unique contributions to the comprehension of the “pathogenic role of inequity” (2005:20) by calling for a triumvirate analytical framework that includes geographic breadth, historical depth and an investigation of various axes of power (2005:42-43). Farmer draws inspiration from liberation theology and proposes that anthropologists and public health workers must have a “preferential option for the poor” (2005:139) including those considered “undeserving” poor such as drug users, undocumented individuals, the homeless, and sex workers (2005:6). He urges researchers and healthcare workers to explicitly position themselves on the side of the disadvantaged through “pragmatic solidarity” (2005) as a strategy to address structural violence and human rights abuses that are byproducts of



systematized poverty. Inclusion in social and political life, including access to the resources necessary to live, is essential to human rights. The consequences of exclusionary practices are deep and wide, and the toll of infectious disease ripples beyond the “undeserving” poor.

### *Evidence-based Practices*

Harm reduction, as noted in previous chapters, is rooted in grassroots movements particularly AIDS activism. Gone are the days of Jon Parker getting arrested for dispensing clean syringes to drug users—in many states anyway. Now, harm reduction has the scientific rigor and data to prove its efficacy in reducing risk and disease prevention. Moreover, multiple harm reduction interventions have become mainstream, (though not universally accepted) including syringe services programs, medication assisted treatment, overdose prevention (naloxone), Good Samaritan laws, supervised injection sites, and science-based sexual education programs—all of these interventions work to eradicate stigma by providing education and inclusion.

According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), harm reduction has been used successfully in a variety of interventions. Most notably, harm reduction is an important component in the Housing First Model which emphasizes that housing is a basic right and as such does not require prerequisite sobriety and/or engagement with services. Rather, Housing First works to reduce homelessness by placing individuals into housing while using harm reduction and motivational

interviewing to work with consumers to identify their own goals regarding health, mental health, and sobriety. This model, according to SAMHSA, is effective with individuals living with mental illness, co-occurring disorders, and substance use (NREPP n.d.). Harm reduction, in conjunction with supportive housing services, intensive case management, has worked in hundreds of cities and has proved to be a cost-effective solution to homelessness, high utilization of emergency departments, hospitals, psychiatric hospitals, and jails.

### Peer Support

Peer support is not a new concept; however, the value of lived experience is gaining traction across numerous domains of healthcare interventions. Peer support is the central to groups like Narcotics Anonymous, Alcoholics Anonymous, and other twelve-step groups. In mental health, the peer support movement began in the 1970's as a response to the often brutal treatment people living with mental illness experienced within institutions (Mental Health America n.d.). Peer support networks help to create a sense of solidarity and community for individuals who may face isolation and social exclusion as they benefit from a positive peer social network while working towards the goal of recovery. There are now national certification programs that train peers to provide support by using evidence-based practices such as trauma informed care, motivational interviewing, and harm reduction. Peer support specialists can be found in a variety of places ranging from Assertive Community Treatment teams, outpatient mental health

centers, community health centers, insurance companies, and hospitals. Community Health Workers are also often peers of the communities they work within.

### Circling Back

Throughout this thesis, the scope has often shifted between macro processes and microinteractions.. This shifting of scope is not meant to confuse the reader, rather it is meant as a heuristic device that fosters an integrated understanding of the complexities of homelessness and drug use as well as the tension between policies and practitioners. The constant vacillation between macro and micro was necessary to unravel the historical depth of drug ethnography, harm reduction discourse, and the spatial politics of the physical place of Change Point.

While the physical location of Change Point as a syringe services program has remained static, the social aspect is dynamic and directly relational to the actors who create, maintain, or contest Change Point's social space. Geographer Ray Hudson states that "spaces, flows and circuits are socially constructed, temporarily stabilized in time/space by the social glue of norms and rules, and both enable and constrain different forms of behavior" (2004:463). The social atmosphere has changed drastically since my fieldwork in 2014 and the social norms within the space seem dependent on the actors present. Only one staff member from the interviews remains, all of the volunteers have moved on, and many of the clients have become housed or abstinent from substances and have found other things to occupy their time rather than sit in the lobby of Change Point. The "social glue" of Change Point is harm reduction discourse and the commitment to

provide a safe-space for marginalized individuals wherever they may be on the continuum.

### Implications

The ethnographic data collected from this project, in addition to all of the fliers, pamphlets, training materials, and other written materials that I gathered (fueled by my paranoia that I may not get enough ethnographic data so I prepared for discourse analysis) was so extensive that it could have gone in many directions. I thought of several ideas for future research projects that would add to understanding social spaces in relation to marginalized communities and health interventions.

I am not alone in understanding the critical role of safe spaces for socially excluded individuals. On a visit to Central City Concern (CCC), a large FQHC in Portland, in January 2017 myself and members of the executive team of Northern Nevada HOPES were taken on a tour of their Old Town Recovery Center and Clinic. One of the places we visited (the Living Room) was an area that existed as a social space for people living with mental illness or co-occurring disorders. This area was a very large room with high ceilings and many windows. There were multiple options for seating, games, activities, and a giant industrial kitchen. Although there were only a couple of people in the room when we visited, the intention of this room is to create a social space for people living with severe mental illness to socialize, build positive peer networks, and connect with professionals who coordinate their care and lead groups. According to the CCC's website, "The Living Room is a shared, safe place for OTRC patients, many of whom are actively living with and managing behavioral and mental illness. It functions as a place

for clients to come and engage in group sessions, hang out, find community, and participate in group activities” (2015). In a three-part series on volunteering in the Living Room, volunteers cite a desire to be “of service” and create a space of “open-mindedness” (Central City Concern 2015). Volunteers are also driven by the social relationships that are created in this space, the coordinator states, “the relationships. The people. Volunteers are struck by the kindness. Some of our members may present themselves in a way that might scare people at first, but eventually volunteers don’t want to leave because of the relationships they make” (2015).

On another tour of new medical and psychiatric facility in Reno that serves Amerigroup members, I was taken to a house next door that functions as a social space for their consumers. This house feels like a home where one feels compelled to sink into one of the overstuffed recliners and socialize, read, or watch television. Many of the staff reported that it was in the house, not the clinic, that “the magic happens,” which I take to mean that the nature of the place influences the interactions of the social space.

These two examples illustrate the importance of creating socially meaningful spaces in conjunction with healthcare centers, however, they do not incorporate syringe services, HIV/HCV testing, safe sex supplies, and a drop-in center as Change Point does. From January 2014 to May 2017, Change Point existed as Nevada’s only syringe program, leaving healthcare providers in Northern Nevada to question why Las Vegas in Southern Nevada did not pursue syringe access after the passage of SB 410. In May 2017, Trac-B opened in Las Vegas, launching its first in the U.S. syringe vending machine program. The vending machines also offer wound care kits and safe sex supplies and consumers are able to acquire two kits per week with their swipe card. As

with most prevention and treatment programs, funding for syringe services is unstable and fickle. Historically, funding for syringe services were banned by Congress, however, under the Obama administration the ban was lifted. Ironically, funding is tied to strict guidelines and cannot be used to purchase syringes (HIV.gov 2017).

Vending machines that distribute syringes, safe sex supplies, and wound care are an interesting idea and a means to decrease barriers to injection drug users. However, vending machines lack the human interaction that creates trusting relationships. It is these trusting relationships and rapport building that Alex Wodak and Annie Cooney (2004) discuss as the unanticipated benefits of SSPs. In an effort to highlight an example of unanticipated benefit, I would like to offer a story from my time volunteering while conducting participatory action research for this project. One of the consumer interlocutors, “Glitterman,” would come in with terrible track marks and large lumps from “missing.”<sup>22</sup> Each time I saw him, we would chat about the importance of hydration and I would inquire about how much water he was drinking and the importance of alternating injection sites. Glitterman hated water so I suggested adding a flavor enhancer and brought him a small bottle that I purchased at the store for him. He would often stop by just to show me that he was drinking water enhanced with the flavoring. After a while, he stopped by less frequently and was employed and living inside at a monthly motel. Many months later, he came by to let me know he no longer felt the need to use. This story emphasizes the importance of social interactions at an SSP and the unanticipated benefits that can come with a simple social interaction about hydration as a mechanism to

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<sup>22</sup> “Missing” means to miss the vein during injection, often resulting in an intermuscular or subcutaneous mass that is often painful or may result in an abscess.

reduce harm. During my year volunteering at Change Point, it was a common occurrence for individuals to come in and request the staff member that assisted them in getting into residential treatment. They always came to say, “thank you” and boast about their time sober.

There are several directions future research could take. Comparative analysis of various syringe services programs, including vending machines, could illustrate the ways in which PWIDs understand harm reduction. Another project could focus on individuals that benefit from sterile injection supplies from their friends but are apprehensive about coming into Change Point themselves. Another study could examine community perceptions, including ideas and attitudes of law enforcement officers in relation to syringe access. Further research into “doing” harm reduction (to others) versus actually practicing it in one’s daily life could unravel constructions of broad discursive arenas and the ways in which they become undone by addiction and homelessness.

The most compelling implication of this research, to me at least, is the idea of consumer-centered health interventions by creating thriving third spaces for those marginalized elsewhere. I have been fortunate to have had the opportunity to practice case management in a clinical setting, housing case management, and intensive case management shaped by the Assertive Community Treatment (ACT) model. The latter, which meets consumers quite literally where they are: in encampments, parks, riverbeds, under bridges, in their homes, hospitals, etc. creates a social dynamic that cannot exist within a clinical office. It is in these places, the places where people are comfortable, that “the magic happens.”

As an introvert who was once diagnosed with Social Anxiety Disorder, it is ironic that I would end up applying a theoretical framework that focuses on the power of positive social networks. The truth is, observant participation and ethnographic research drew out those themes from this space and made me a believer in the power of social interactions for people that are excluded elsewhere to be a factor in healing, wholeness, and reintegration into other social spaces. This humanization through sociability empowers consumers to build community, focus on resilience through suffering, foster incremental change, and create a path to accessing services such as healthcare, addiction treatment, mental health, housing, and case management.

There are multiple ways that healthcare, mental health, and supportive services professionals could work within spaces of inclusion to engage individuals in a variety of client-centered services. Unfortunately, during my time volunteering and doing research, these wellness interventions did not occur—at least not with professionals beyond the CHWs within Change Point. The only time healthcare professionals came to Change Point during my time there was to respond to mental health or medical emergencies. Spaces of inclusivity could be utilized by healthcare professionals to engage with medically underserved populations to understand individuals *in situ*.

Research on spaces of inclusion for those on the margins directs us to look beyond the suffering subject, or “the savage slot” (Robbins 2013) to see the ways in which what may appear to be suffering, through a white middle-class logic, is actually thriving through challenges. Seeing situations, communities, and individuals in terms of resiliency rather than the sum of their traumas, fosters deeper possibilities for change, hope, and the belief that we can help shift the narrative from victim to victor.



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